C+D
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10 July 2010

Taking stock

Government in secret talks on medicines shortages page 4
Ministers quizzed over patient waiting times page 4
Stock Survey 2010 – tell us how bad it is page 12

CPD ZONE

Taking an aggressive approach to rheumatoid arthritis page 16
SPOTTING THE SIGNS OF CANNABIS ADDICTION page 20
Weight loss services: what your patients think page 22
KNOW YOUR RIGHTS ON SICK PAY page 25

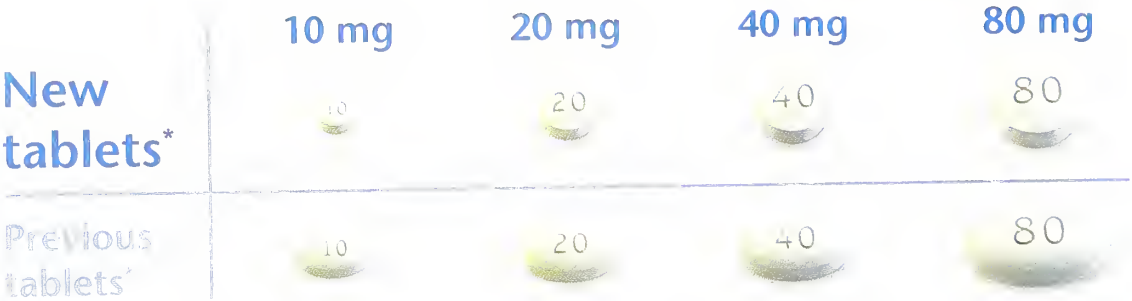
Introducing Lipitor in a smaller size

Same Lipitor.
Same cardiovascular benefits.[1]

Lipitor is now available in a smaller size. The size and shape of the tablets are new, and the cardiovascular benefits[1] remain the same. The 80 mg pack in particular is much smaller.

Reassure your patients that their treatment will offer the same cardiovascular risk reduction[1] as always.

†Not actual size.



*Actual size.

LIPITOR atorvastatin

Abbreviated prescribing information: Lipitor®
Presentation: Lipitor is supplied as film-coated tablets containing 10mg, 20mg, 40mg or 80mg of atorvastatin.
Indications: In patients unresponsive to diet and other non-pharmacological measures, Lipitor is indicated for the reduction of elevated total cholesterol, LDL-cholesterol, apolipoprotein B, and triglycerides in adults and children aged 10 years and older with primary hypercholesterolaemia, heterozygous familial hypercholesterolaemia or combined (mixed) hyperlipidaemia. Lipitor also raises HDL-cholesterol and lowers the LDL/HDL and total cholesterol/HDL ratios. Lipitor is also indicated for the reduction of elevated total cholesterol, LDL-cholesterol, and apolipoprotein B in patients with homozygous familial hypercholesterolaemia. Lipitor is indicated for reducing the risk of cardiovascular events in patients with Type II diabetes and one additional risk factor, without clinically evident coronary heart disease, irrespective of whether cholesterol is raised.
Dosage: The usual starting dose is one Lipitor 10mg tablet daily. Doses should be individualised according to baseline LDL-C levels, the goal of therapy, and patient response. Doses may be given at any time of the day with or without food. The maximum daily dose is 80mg. For patients taking drugs that increase plasma exposure of atorvastatin the starting dose should not exceed 10 mg and maximum dose of less than 80 mg may have to be considered. Doses above 20mg/day have not been investigated in patients aged 18 years. In primary prevention trials, the dose was 10mg/day.
Contraindications: Hypersensitivity to any of the ingredients, active liver disease, unexplained elevations in serum transaminases, pregnancy and breast-feeding and in women of child-bearing potential not using contraception.
Warning and precautions: Liver function tests should be performed before initiation and periodically thereafter and in patients who show signs and symptoms of liver injury (monitor raised transaminases until they return to normal). Drug dosage should be reduced or therapy discontinued if persistent elevations occur above 3-times the upper limit of normal. Lipitor should be used with caution in patients with a history of liver disease and/or alcoholism. For patients with prior haemorrhagic stroke or lacunar infarct, the balance of risks and benefits of atorvastatin 80 mg is uncertain and the potential risk of haemorrhagic stroke should be carefully considered before initiating treatment. Patients with signs and symptoms of myopathy should have their creatine phosphokinase (CPK) levels monitored. Lipitor should be discontinued if CPK levels are markedly or persistently raised or myopathy is diagnosed or suspected. Lipitor should be prescribed with caution in patients with pre-disposing factors for rhabdomyolysis. Risk of myopathy may increase when administered with certain medications that increase the plasma concentration of atorvastatin. If co-administration is required a dose reduction or if not practical a temporary suspension should be considered; the starting dose of atorvastatin should be 10 mg. In the case of ciclosporin, clarithromycin and itraconazole a lower maximum dose should be used. Although interaction studies with atorvastatin and fusidic acid have not been conducted, severe muscle problems such as rhabdomyolysis have been reported in post-marketing experience with this combination – therefore patients should be closely monitored and temporary suspension of atorvastatin treatment may be appropriate. As with other statins, rhabdomyolysis with acute renal failure has been reported. A history of renal impairment may be a risk factor for rhabdomyolysis. Exceptional cases of interstitial lung disease have been reported with some statins and statin therapy should be discontinued if a patient is suspected to have developed interstitial lung disease. Patients with galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this product.
Pregnancy and lactation: Lipitor is contraindicated in pregnancy and lactation.
Side effects: Side effects most frequently reported in controlled clinical studies: nasopharyngitis, hyperglycaemia, pharyngolaryngeal pain, epistaxis, constipation, flatulence, dyspepsia, abdominal pain, headache, nausea, arthralgia, myalgia, pain in extremity, musculoskeletal pain, muscle spasms, joint swelling, asthenia, diarrhoea, insomnia, abnormal liver function tests, elevations in ALT and CPK levels. Other side effects have been reported in clinical trials and post-marketing (See Summary of Product Characteristics).
Legal category: POM.
Date of Revision: December 2009
Package quantities, marketing authorisation numbers and basic NHS price: Lipitor 10mg (28 tablets), PL16051/0001 £13.00, Lipitor 20mg (28 tablets), PL16051/0002 £24.64, Lipitor 40mg (28 tablets) PL16051/0003 £24.64, Lipitor 80mg (28 tablets) PL 16051/0005 £28.21.
Marketing Authorisation Holder: Pfizer Ireland Pharmaceuticals, Pottery Road, Dun Laoghaire, Co. Dublin, Ireland.
Lipitor is a registered trade mark.
Further information is available on request from: Medical Information, Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS.
Ref: LR 12_1.

Reference: 1. Colhoun HM *et al. Lancet* 2004; 364: 685-696.

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> CIVIL SERVANTS HAVE RACKED UP OVER A DOZEN MEETINGS – THAT'S A LOT OF BISCUITS THAT COULD HAVE BEEN TRIMMED FROM PUBLIC SECTOR SPENDING

Red tape to the coalition government is like a red rag to a bull. Cameron, Clegg and co want to cut PCT admin costs by a third and ditch health quangos according to their NHS vision. Their reaction to the latest efforts to solve stock shortages might therefore make for interesting viewing (p4).

A Department of Health (DH) led steering group has met with manufacturers whose medicines are reported on an official shortages list (p4). At first sight this appears a sensible move. There are many sides to the stocks saga and getting the manufacturers together to agree an effective resolution is crucial.

The trouble is the DH didn't. Separate meetings have been set with each firm, which is an unnecessary duplication of resources. Civil servants have racked up over a dozen meetings – that's a lot of biscuits that could have been trimmed from public sector spending.

The format also seems counter productive. Moves to solve stock shortages have been about setting aside individualism for the greater good. Bringing manufacturers into the same room would have reinforced this ethic.

Obviously there are practical issues – you'd need a big table to host the numerous representatives affiliated to more than a dozen manufacturers and the parties that make up the steering group.

But, you could break the sessions down into smaller focus groups to target specific actions. That would give manufacturers the opportunity to exchange views on the UK supply chain. Swapping experiences with contemporaries is a great way to spark ideas and fresh thinking is just what we need to solve shortages.

Sure these firms are fierce rivals, but that shouldn't get in the way. Just look at wholesaling – an area of the supply chain also subject to some bitter competition. At last year's C+D Conference, the heads of the two biggest players, AAH and Alliance Healthcare, united to tackle stock shortages.

It's an example of the open approach we need. The final action point from the previous stock summit in March highlights the importance of exchanging information to avoid shortages. Strange then that a series of talks on the matter should employ confidentiality clauses to keep things under wraps.

Amid this culture of secrecy, it's quite difficult to grasp whether stock shortages have got any better. C+D has brought back its Stock Survey – first published a year ago – to shed light on matters. We plan to benchmark the findings against our 2009 data. For the results to carry weight, we need as many of you as possible to fill in and return the survey on p12.

It's up to us to kick off the spirit of collaborative working that could finally end the stock shortages saga.

Max Gosney, News Editor

4 Stock measures imminent
5 RPSGB disciplinary delays under fire
6 Sector poised for flu jab contract
8 Pharmacist kept off register
10 Mentholatum UK – products and plans
12 Stock shortages survey – win an iPod
14 Letters – Mark James and Mimi Lau
15 Xrayser and David Reissner
26 Classified
30 Postscript – charity summer bonanza

16 Update: Managing rheumatoid arthritis
How treatment limits disease progression
20 Practical Approach
How do you recognise cannabis addiction?
22 Weight management
Two pharmacies – two approaches to losing weight
25 Jobs
Your rights when you're ill

Stock measures imminent as secret supply talks revealed

EXCLUSIVE Clamp-down on parallel trading to feature in measures to guarantee medicine stocks

Max Gosney
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The government is set to publish a raft of measures to combat stock shortages after secret talks with manufacturers who have been linked to supply problems.

Companies whose medicines feature on an official PSNC shortages list have been called to discussions at the Department of Health (DH), C+D can exclusively reveal.

Pharma firms have been quizzed by a cross-party medicines supply chain group set up to implement the findings of a ministerial stock summit in March.

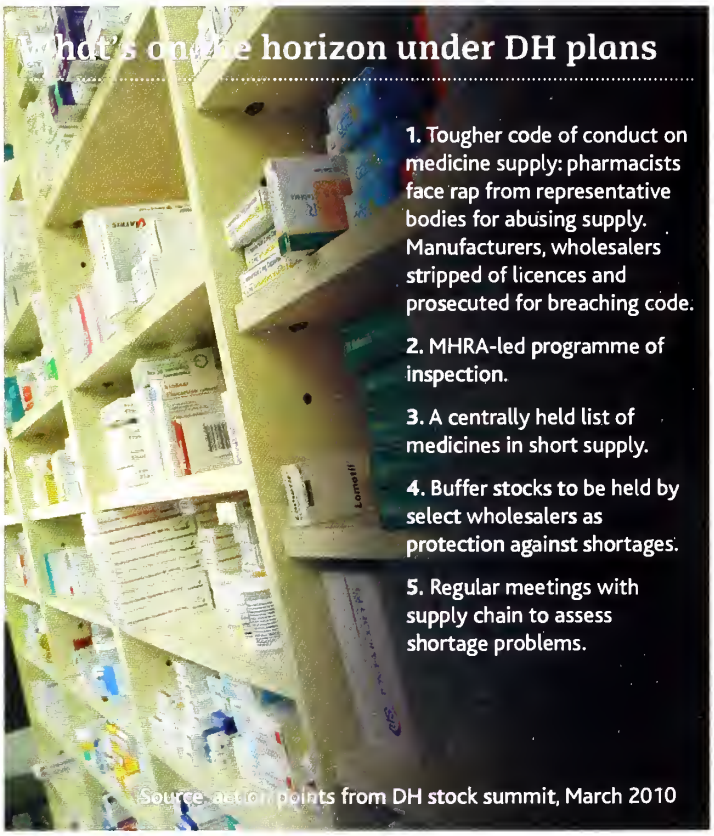
The talks between pharmacy, DH, wholesaler and manufacturer representatives were subject to a confidentiality agreement. However, meeting insiders have leaked key details to C+D this week.

Talks have centred on establishing a tougher code of conduct to stop stakeholders manipulating medicine supply, sources revealed.

A clampdown on pharmacists who breach their ethical duty to patients by parallel trading is being investigated, one said.

A meeting attendee told C+D: "We're having a conversation in terms of understanding the issues and sharing best practice to address them."

Another insider added: "The idea is to move to the agreed outcomes of the stock summit earlier this year... I think it's fair to say that there will be an update on the outcomes in the next few weeks."



What's on the horizon under DH plans

1. Tougher code of conduct on medicine supply: pharmacists face rap from representative bodies for abusing supply. Manufacturers, wholesalers stripped of licences and prosecuted for breaching code.
2. MHRA-led programme of inspection.
3. A centrally held list of medicines in short supply.
4. Buffer stocks to be held by select wholesalers as protection against shortages.
5. Regular meetings with supply chain to assess shortage problems.

Source: action points from DH stock summit, March 2010

Manufacturers whose medicines feature on the PSNC shortage list are involved in the talks, the source revealed. There are currently 16 firms on the list.

Each manufacturer will hold a separate meeting with the group rather than a discussion between all parties, the source revealed. This is partly due to commercial sensitivities, one manufacturer told C+D.

A meeting source said he did not believe the fragmented nature of discussions would hinder progress as each manufacturer operated a different medicine supply model.

The ABPI said it was working with all parties to ensure UK patients continue to receive their medicines.

The DH said all the parties in the supply chain had continued to work together and the talks had "made good progress" in agreeing measures set out at the stock summit in March.

Supply standards needed

The government should decide on acceptable standards for supplying medicines to patients in a timely manner, experts have said.

Martin Sawer, executive director of the British Association of Pharmaceutical Wholesalers (BAPW), told C+D that industry stakeholders at the BAPW's annual conference felt there needed to be standards on what patients and the NHS wanted from the supply chain. "What is timely for patients? Emergency deliveries come the next day, but is that what pharmacists and patients are going to have to put up with?"

Mr Sawer said that when standards had been set, the supply chain could work towards meeting them.

He added that stock shortages seemed to have improved in the first three months of 2010 but were worsening again. "It has started to slip again... pharmacists are having to spend more and more time trying to source stocks." **ZS**

Adrian Sanders: acted in response to complaints from pharmacy groups

MP quizzes Lansley on shortages

An MP has highlighted the impact of stock shortages to the health secretary Andrew Lansley.

Adrian Sanders MP submitted a written question that asked how many patients had to wait more than 48 hours for their prescriptions to be dispensed.

The Torbay MP said that as chair of the all-party diabetes group he had been made aware of stock shortages of certain medicines.

Constituents and pharmacy groups had also written to him complaining about medicine shortages, he told C+D.

Mr Sanders said: "It seems to stem from companies being able to trade across international boundaries.

"It stopped briefly as the pound was weak but as the pound gets stronger against the Euro the trade may start again."

He added: "There is still the possibility shortages will continue."

The MP submitted further questions to the health secretary asking what cost savings could be attributed to parallel trading.

Simon Burns MP responded to the question and said: "The Department continues to work collaboratively with supply chain organisations to explore further measures to help alleviate the situation." **HF**

RPSGB under fire over delays to disciplinaries

Pharmacists made to wait over five years for initial hearings

Zoe Smeaton
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Over 130 pharmacists are still waiting for an initial hearing from the RPSGB's disciplinary committee concerning allegations about their practice. And some have had the accusations hanging over them for over five years, experts warned.

The figures come despite moves by the Society to reduce the number of pharmacists being referred to its statutory committees.

A statistical report by the RPSGB shows that between January and April this year, 42 cases were heard by the disciplinary committee and 89 by the investigating committee. Of the latter, 12 per cent were referred to the disciplinary committee, 17 per cent were dismissed or no action was taken and 53 per cent were dealt with by letter of advice or warning.

Of the cases where no further action was needed, 38 per cent referred to allegations of failure to adhere to professional or legal standards of practice and 24 per cent to dispensing errors.

The Society also reported that since November 2007, 407 fewer cases of single dispensing errors were referred to the investigating committee. But it said 188 pharmacists were awaiting hearings by the disciplinary, health and registrations appeals committees, with 134 still waiting for a principle hearing with the disciplinary committee.

Noel Wardle, a solicitor with Charles Russell LLP, agreed more cases were being dealt with by warning letter where pharmacists admitted to the allegations. But he said the improvements were having no effect on the time being taken to hear disciplinary committee cases.

One case referring to an incident in 2005 had still not been heard, he said. "That's not unusual and there does seem to be some inefficiency in the system," he warned. He added that delays were in nobody's interest and increased costs for everybody.

The Society said it was "working very hard" to ensure that the list of cases transferred to the GPhC when it takes over regulatory powers was the minimum number possible.

Stat Comm figures

134
Cases awaiting principle hearing by disciplinary committee

347
Complaints under investigation

53%
Committee cases dealt with by letter of advice or warning

Source: RPSGB Council papers, June 2010

C+D shows off London's best

C+D will be touring pharmacies across London this month to raise awareness of innovative public health services – and we want to put your pharmacy on the map.

A National Audit Office report found London "makes more use of pharmacies" for health interventions than other areas.

From July 26-30, our team will visit pharmacies in a range of PCTs, each offering a different enhanced service. We will interview the pharmacist about the difference the service has made. The results will be delivered to the mayor of London Boris Johnson. **CC**

To get involved and have the C+D team visit your pharmacy, email chris.chapman@ubm.com

Government urged to outline future plans

The new government must outline its plans for community pharmacy with urgency and must not overlook the sector, the NPA has warned.

Following the association's latest board meeting, chairman Ian Facer told C+D: "Our concern is that, as you would expect with a new health secretary coming in with their own thoughts and ideas, they will be looking to introduce new strategies."

He said the government needed to outline any such thoughts on pharmacy quickly, warning that contractors who had invested in premises and staff to offer new services had been left not knowing whether the benefits of that would be realised.

The NPA had written to Andrew Lansley and pharmacy minister Earl Howe, Mr Facer said, to stress the urgency of developing community pharmacy. He said the association hoped to have a meeting with Earl Howe towards the end of summer and would tell him how community pharmacy could help to reduce waste in the NHS and work to improve public health.

Ian Facer: contractors who have invested heavily need assurances fast

"What we want as soon as possible is the opportunity to shape the policy," he said.

The Department of Health confirmed it was still reviewing the pharmacy white paper against its own health priorities. **ZS**

In brief

Sinemet campaign

A Parkinson's charity has called for action on global shortages of Parkinson's drug Sinemet. Parkinson's UK is demanding that manufacturer Merck takes more responsibility for communicating about supply issues.
www.chemistanddruggist.co.uk

CIP payment checks

The NHS Business Services Authority has confirmed it is now collating requests from contractors to check CIP payments to the end of March 2009. The authority will discuss the information received with the DH before determining the next steps in the process.

Victorian Pharmacist

The Victorian Pharmacist will make his TV debut on Thursday at 9pm on BBC2. The show, titled The Victorian Pharmacy, stars RPSGB vice-president Nick Barber. The show looks at medicines and cures from the 19th century. To review the show for C+D, email **chris.chapman@ubm.com**

NCSO update

The DH and National Assembly for Wales have agreed to allow NCSO endorsements for nizatidine 300mg capsules for July prescriptions.

SCC lobbies Lansley

The Self Care Campaign has requested a meeting with health secretary Andrew Lansley to highlight how self-treatment can cut NHS spending. It estimates £2bn could be saved by increasing self-management of conditions.
www.chemistanddruggist.co.uk

Commissioning awards

Entries are now open for the Acorn Awards 2010, which will honour PCTs excelling at commissioning pharmacy services. Judges include PSNC chief executive Sue Sharpe and DH community pharmacy tsar Jonathan Mason.
www.nhsalliance.org

Survey winner

Congratulations to Jatinder Rai, of Lloydspharmacy Sunningdale, who was randomly selected from respondents to C+D's swine flu survey and wins an iPod Shuffle.

In brief

Diabetes doubts rife

More than three quarters of pharmacists do not feel they know enough about newer treatments for diabetes to perform MURs, a survey has revealed. Only 4 per cent and 2 per cent felt they had a thorough understanding of DPP-4 inhibitors and GLP-1 analogues respectively, a survey of 200 pharmacists found.

Superdrug £6m profit

Financial reports for Superdrug, filed this week, show an operating profit for 2009 of £6 million compared with an operating loss for 2008 of £2.4m. The improvement follows cost savings, improved margins and tightened control of slow-moving stocks.

Ryder cup bid

Independent pharmacy support group Cambrian Alliance has been contracted to manage the on-site pharmacy at the Ryder Cup at Newport in October. Cambrian is to work with the golf event organisers to build, stock and manage a facility at the event.

Servier supply deal

Servier Laboratories is to restrict distribution of its products to just three wholesalers – Alliance Healthcare, Phoenix Healthcare and AAH Pharmaceuticals. The new supply chain arrangements will be in place from August 1.

Co-op gets ethical

The Co-operative Pharmacy has launched an ethical strategy that the group claims will reinforce the organisation's commitment to responsible retailing, combating climate change and caring for communities. The strategy will include a three-year partnership with children's charity UNICEF.

Healthcheck events

Pharmacist Bobby Mehta, founder of the Sunday Morning Soccer service, is to run local healthcheck days at community events in an area just west of London. BMI, blood pressure and diabetes checks will be offered.

More on all these stories at
www.chemistanddruggist.co.uk

Sector poised for flu jab 'sleeping contract'

Negotiations set to start for pharmacy pandemic-vaccination deal

Chris Chapman
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Negotiations for pharmacists to provide vaccinations in the event of an influenza pandemic are poised to start, the Department of Health (DH) has revealed.

The news comes as a C+D survey reveals more than half of pharmacists want a national plan in place for pharmacy to improve the sector's response to future pandemics.

The negotiations follow recommendations in an independent review of the UK's response to last year's H1N1 pandemic by former chief medical officer of Wales Deirdre Hine, published last week.

In her report, Dame Deirdre suggested a "sleeping contract" for any emergency vaccination programme, agreed in advance "with GPs or willing providers such as community pharmacists" and to be activated in a pandemic.

"A sleeping contract would allow difficult negotiations to be undertaken in a more reasonable timeframe than is possible during a pandemic," Dame Deirdre said.

"I understand that preliminary discussions on such a sleeping contract are already taking place," she added.

Both the DH and PSNC head of pharmacy practice Barbara Parsons confirmed that the possibility of a sleeping contract for pharmacy had been raised.

The independent report comes as a C+D straw poll of 43 readers found eight out of 10 pharmacists feel the UK's response to the swine flu pandemic was well organised, with good information from PCTs and LPCs.

However, more than 50 per cent felt a national response plan to pandemics would have improved the sectors response to swine flu, with one in three calling for improved communication to the sector.

Clinical debate — C+D's Chris Chapman looks at the evidence behind the headlines

Rich-poor gap hints at new role

Last week, the nationals revelled in old cliches about the health differences between rich and poor after the National Audit Office (NAO) exposed a gulf in patient health.

Reading between the lines of the report, it could be the government intends for pharmacy to play a substantial role in the solution to this public health puzzle.

According to the report, the health disparities are across the board. When compared with affluent patients, those from deprived backgrounds are more likely to smoke (smoking rates are 169 per cent higher) be obese (22 per cent higher), have type 2 diabetes (77 per cent higher) and be at high risk of cardiovascular disease (22 per cent higher). Even medicines prescribing suffers: 21 per cent of those better off with CVD are on a statin, compared with 19 per cent for deprived patients.

What's being done? The report says nobody really knows. "PCTs are not allocated funding specifically to tackle health inequalities," the NAO states, "but are required to address health inequalities from within their general funding allocations."

While PCTs in spearhead areas (ie most deprived) get roughly an extra £230 per head to deal with health problems, the report adds: "There is evidence that some of the extra money has been absorbed by funding higher hospital costs in deprived areas."

The silver lining to this cloud is that it's another opportunity for pharmacy to step up to the plate.

Smoking cessation, CVD checks and independent prescribing could all make a difference to these statistics, especially with the advent of Healthy Living Pharmacies.

But perhaps the best news for pharmacy is contained in the report's recommendations. According to the NAO, in the future there needs to be the implementation of proven, cost-effective services, targeted specifically at those who need them; publicly available information on commissioning results; costed proposals for increasing investment in tackling conditions such as CVD; and practical guidance on how to overcome barriers to reaching these hard to target patient groups.

Is it just me, or is the report talking about pharmaceutical needs assessments?

To discuss this subject in private with your pharmacy colleagues, join the debate in C+D's Linkedin group at www.linkedin.com – search for Chemist and Druggist.

Chat with Chris on Twitter: www.twitter.com/CandDChris

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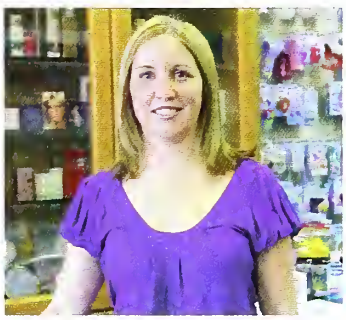
Dispensary talk

Will you accept the swine flu jab?

"I have had the swine flu vaccine because every day I deal with elderly customers and young children, and we work next to a health centre so I am in the frontline."
Julie Key, Murrays Healthcare, Tipton



"I would not have it because at the moment there is no evidence that the swine flu strain is virulent, so I would rather catch the virus and develop natural immunity as I am not in an at-risk group."
Elaine Stevenson, Medipharmacy, Wallington

Web verdict

Yes – it's important to take up this right 39%

No – I'll take my chances 61%

Armchair view: There is no consensus from pharmacists on the swine flu vaccine, with 61 per cent of respondents saying they are happy to take their chances with the virus. On the other hand nearly two in five think it is important to get the same protection as other frontline staff.

Next week's question:
Did you take any time off work to watch the World Cup? Vote at **www.chemistanddruggist.co.uk**

Pharmacist guilty of fraud kept off register

Public confidence could be damaged, says committee chairman

Max Gosney
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A pharmacist struck off for defrauding over £5,000 from the NHS has failed in his bid to be restored to the register.

Reinstating John Wesley Gilpin would damage public trust in the profession, an RPSGB disciplinary panel ruled last month.

Mr Gilpin pocketed between £78 and more than £700 a month filing false prescription claims between 2000 and 2002.

The fraud took place while Mr Gilpin was the manager of a pharmacy in Portadown, Northern Ireland. He also owned two pharmacies in Scotland and filed claims with the NHS Scotland Practitioner Services for prescriptions issued in Northern Ireland that had not been dispensed.

The gravity of his offences ruled out a return to practice despite Mr Gilpin having nearly served the recommended five-year absence from the register, the panel said.

Statutory committee chairman, Patrick Milmo QC said: "The question we must ask is how will the public at large react in terms of confidence in the profession if his name was now restored. We have concerns that public confidence would be damaged."

Mr Gilpin had returned to pharmacy, working as a dispenser, the panel heard.

He had repaid the £5,371 he pleading guilty to taking in false prescription claims and additional sums not subject to charges.

Mr Gilpin had also completed a return to practice course, the hearing was told.

He would not represent a danger to the public if restored to practice, Mr Milmo added.

But Mr Gilpin was criticised for showing "limited insight" into his offences. Mr Milmo said: "The best he could do was to use phrases [such] as 'I cannot explain why I acted in this way', and 'there was no logical reason for me so acting'."

Although his restoration bid was rejected, Mr Milmo stressed that another application could be made in 12 months.

What are your rights when you're absent due to illness?
See our guide on p25

Combined oral contraceptive range launches

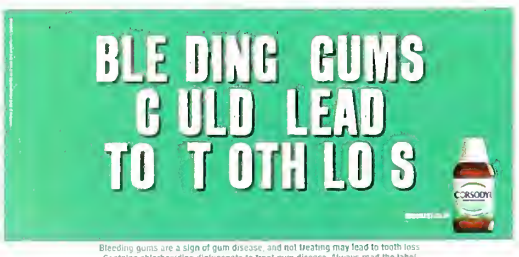
Consilient Health has announced the launch of a "comprehensive" range of combined oral contraceptive brands with partner Gedeon Richter.

The companies will be promoting these brands to healthcare professionals and PCTs over the coming months, it says. A website is also due to be launched, which will contain information for healthcare professionals.

The new range comprises the Rigevidon, Gedarel, Millinette and TriRegol brands.

Prices: £1.89/21x3 (Rigevidon); £4.93/21x3 (Gedarel 20/150mcg); £5.98/21x3 (Gedarel 30/150mcg); £4.85/21x3 (Millinette 20/75mcg); £6.37/21x3 (Millinette 30/75mcg); £2.87/21x3 (TriRegol)
Pip codes: 355-7923; 355-9309; 355-9275; 355-9267; 355-9259; 355-9465
Consilient Health
Tel: 0208 956 2696
www.knowyourcontraceptives.co.uk

£1.6m campaign backs Corsodyl mouthwash



Bleeding gums are a sign of gum disease, and not treating may lead to tooth loss
Contains chlorhexidine digluconate to treat gum disease. Always read the label.

Corsodyl mouthwash is set to be the focus of a £1.6 million advertising campaign this summer, GSK Consumer Healthcare has announced.

The three-month campaign features television, press and outdoor advertising.

The outdoor campaign will break in mid-July, with 2,500 posters nationwide, says the manufacturer.

Additional support will come from a national press campaign from mid-July to the first week of August to support Corsodyl Mint mouthwash and Corsodyl Daily Defence mouthwash, the company adds. This will follow a four-week TV campaign.

Prices: £4.69/300ml, £9.19/600ml (Mint mouthwash); £4.49/500 ml (Daily Defence mouthwash); £4.00/75ml (Daily gum & tooth paste)
Pip codes: 094-8083, 227-7028; 329-3834; 343-8678
GSK Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

Nicorette® Inhalator

nicotine

first to market with a new indication for those unwilling or unable to quit smoking

In the UK approximately 10 million adults smoke cigarettes. 50% of smokers are not happy with their current smoking habit, of these 12% are planning to stop abruptly and 35% are either planning to reduce the amount of cigarettes they smoke or reduce the amount they smoke with a view to stopping altogether. However, with no help or support the power of nicotine addiction means that few will actually succeed. Research has shown that only 3% of smokers will succeed in an unaided quit attempt in any 12 month period.

A new way to help smokers quit

Pharmacists are among the most accessible of all healthcare professionals. Everyday almost two million people in the UK visit a community pharmacy for health advice[4] making pharmacists ideally placed to provide support to those who are thinking of stopping smoking. Nicotine Replacement Therapy (NRT), along with advice and support, is an effective and simple way to help smokers reach their ultimate goal of quitting.

The Inhalator is a unique format of NRT which acts as a cigarette replacement to help control cravings, with up to one in three smokers remaining abstinent at 12-weeks.[5,6,7,8] It is made up of a mouthpiece through which the user draws in nicotine by active inhalation. Held like a cigarette, it occupies the hand as well as mimicking the hand-to-mouth action.

As well as controlling cravings, Nicorette® Inhalator has been shown to relieve nicotine withdrawal symptoms associated with tobacco dependence[9], and is indicated:

- To aid smokers wishing to quit
- To aid smokers to reduce the amount of cigarettes they smoke prior to quitting
- To assist smokers who are unwilling or unable to quit smoking by replacing some cigarettes with Nicorette® Inhalator for a safer option to smoking

The extension of the indication to encompass those unwilling or unable to quit smoking means you can provide Nicorette® Inhalator as a safer option to smoking when smokers are not yet ready to break free from cigarettes. Data suggests that for smokers unable or not interested in giving up abruptly, a softer and more gradual approach should be considered. Such an approach may produce more people wanting to quit.[10] In fact, one in three of those who halve their smoking with Nicorette® Inhalator or gum have been shown to quit in one year.[11]

Smoking cessation – one step at a time

Five out of 10 smokers are not happy with their current smoking habit.[1] So that the support given to smokers is well-matched to their individual needs, pharmacists should consider the following ways of helping their customers:

- *'Abrupt Quitter' strategy – a smoker who is able to stop smoking immediately, often with the help of NRT and behavioural support.*
- *'Reduce to Stop' strategy – used to encourage those who are not 'abrupt quitters' to build towards a quit attempt by gradually reducing the number of cigarettes used*
- *'Safer Option to Smoking' strategy – used for those unwilling or unable to quit smoking by replacing some cigarettes with Nicorette Inhalator, a safer option to smoking for when smokers are not yet ready to break free from cigarettes.*

Nicorette® Inhalator can now be used in a novel way which will help those smokers who 'cannot quit yet' to replace some cigarettes, as a safer option to smoking. Pharmacists can help patients, who have previously felt they cannot quit, take the first step on their journey with the end goal – smoking cessation – in sight.

Community pharmacists are encouraged to advise on the correct use of nicotine replacement therapy (NRT) products and to provide behavioural support to aid smoking cessation.

For further information on the Nicorette Inhalator visit: www.nicorette.co.uk

"Pharmacists are in a unique position to encourage the use of the Nicorette Inhalator to all smokers including those who continue to smoke, which supports smoking reduction as the first step to cessation. Smoking cessation is no longer about either quitting or not, but instead should be seen as a continuous process that can involve several stages.

Stephen Foster, Pharmacist, Kent

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McNeil

Nicorette Inhalator Product Information:
Presentation: Inhalation cartridge containing 10mg nicotine for oromucosal use via a mouthpiece. Uses: Relieves and/or prevents craving and nicotine withdrawal symptoms associated with tobacco dependence. It is indicated to aid smokers wishing to quit or reduce prior to quitting, to assist smokers who are unwilling or unable to smoke, and as a safer alternative to smoking for smokers and those around them. It is indicated in pregnant and lactating women making a quit attempt. **Dosage:** ***Adults and Children over 12 years of age:*** Nicorette Inhalator should be used whenever the urge to smoke is felt or to prevent cravings in situations where these are likely to occur. Smokers willing or able to stop smoking immediately should initially replace all their cigarettes with the inhalator and as soon as they are able, reduce the number of cartridges used until they have stopped completely. Smokers aiming to reduce cigarettes should use the Inhalator, as needed, between smoking episodes to prolong smoke-free intervals and with the intention to reduce smoking as much as possible. As soon as they are ready smokers should aim to quit smoking completely. When making a quit attempt behavioural therapy, advice and support will normally improve the success rate. Those who have quit smoking, but are having difficulty discontinuing their inhalator are recommended to contact their pharmacist or doctor for advice. **Contraindications:** Children under 12 years and Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, G.I disease, uncontrolled hyperthyroidism, phaeochromocytoma, hepatic or renal impairment, chronic throat disease, obstructive lung disease or bronchospastic disease. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and both less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. Best used at room temperature. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Cough, irritation of throat and mouth, headache, nasal congestion, nausea, vomiting, hiccups, palpitations, GI discomfort, dizziness, reversible atrial fibrillation. See SPC for further details. **RRP (ex VAT):** 6-Starter pack £6.64, 42-Refill pack £20.89. **Legal category:** GSL. PL holder: McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **PL number:** 15513/0179. **Date of preparation:** March 2010

Nicorette Gum Product Information:
Presentation: Nicorette 4mg gum and Nicorette 2mg gum contain 4mg and 2mg of nicotine respectively in a chewing gum base. Original, Mint, Freshmint, Freshfruit and Icy White flavours. Uses: Relief of nicotine withdrawal symptoms as an aid to smoking cessation. Used to help smokers ready to stop smoking immediately and also smokers who need to cut down their cigarette use before stopping. **Dosage: Adults (over 18 years):** No more than 15 pieces of gum should be used each day. Use when there is an urge to smoke. Patients smoking 20 or less a day should use 2mg gum. Those smoking more than 20 should use 4mg gum. Each piece should be chewed slowly for about 30 minutes. Smoking cessation: Patients should stop smoking during treatment. After up to 3 months ad libitum dosage, Nicorette gum use should be gradually reduced. Those who use NRT beyond 9 months should consult a healthcare professional. Smoking reduction: Use the gum between smoking episodes to reduce smoking. A quit attempt should be made as soon as the smoker feels ready but no later than 6 months. Professional advice should be sought if no reduction in 6 weeks or no quit attempt in 9 months. **Adolescents (12 to 18 years):** No more than 15 pieces of gum should be used each day. Smoking cessation: After 8 weeks ad libitum dosage, reduce gum use over 4 weeks. If not stopped by 12 weeks, a healthcare professional should be consulted. Smoking reduction: Only after consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity **Precautions:** Denture wearers, GI disease, unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Headache, sore mouth or throat, jaw-muscle ache, GI discomfort, hiccups, nausea, vomiting, dizziness, erythema, urticaria, palpitations, allergic reactions, reversible atrial fibrillation. See SPC for further details. **RRP (ex VAT):** 2mg gum (10) £2.84, (30) £4.83, (105) £13.23, (210) £22.07; 4mg gum (30) £5.94, (105) £16.12, (210) £27.16. Icy White 2mg gum (30) £5.08, (105) £13.96, 4mg gum (105) £17.09. **Legal category:** GSL. **PL numbers:** Original 2mg 15513/0169, 4mg 15513/0170; Mint 2mg 15513/0171, 4mg 15513/0172; Freshmint 2mg 15513/0173, 4mg 15513/0174; Freshfruit 2mg 15513/0136, 4mg 15513/0137; Icy White 2mg 15513/0152, 4mg 15513/0153. **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **Date of preparation:** March 2010

Dulcolax name change

Boehringer Ingelheim has renamed two products in its Dulcolax laxative range.

Dulcolax Liquid and Dulcolax Perles are named Dulcolax Pico Liquid and Dulcolax Pico Perles, respectively, from this month.

The name change has been made to highlight that both products contain sodium picosulfate, distinguishing them from the bisacodyl-containing products in the Dulcolax range, says the company.

There has also been a change to the licences of the two renamed products and they are now indicated only for the short-term relief of constipation and for the management of constipation of any cause, according to the company.

Previously the products were also indicated for "bowel clearance before surgery, childbirth or radiological investigations".

Prices: £3.25/100ml, £7.75/300ml (Dulcolax Pico Liquid); £2.99/20, £4.59/50 (Dulcolax Pico Perles)
Pip codes: 046-9437, 043-5073; 303-0889, 276-6566
Dendron
Tel: 01923 208141

Market focus

- Constipation affects twice as many women as men.
- Approximately 40 per cent of women experience constipation during their pregnancy.

Source: www.constipationfacts.co.uk

New-look Deep Relief gets £1m promotional campaign

New-look Deep Relief pain-relieving gel is set to be the focus of a £1 million promotional campaign this autumn, Mentholatum has announced.

Television advertising will run in September and will be supported by print advertising in trade and consumer titles.

The campaign will be accompanied by an educational programme that targets pharmacy assistants and medical professionals.

Deep Relief has been repackaged, with the new design highlighting that the gel contains both ibuprofen and levomenthol for two-way pain relief, says the manufacturer.

Prices: £1.00/15g; £3.99/30g; £4.99/50g; £9.99/100g
Pip codes: 214-7205; 244-4818; 211-4890; 224-6841

Mentholatum
Tel: 01202 780558
www.mentholatum.co.uk

Check out what's on TV this week

www.chemistanddruggist.co.uk/prodnews

Brand values

Mentholatum's marketing director talks to C+D

The Mentholatum company has come a long way since Albert Alexander Hyde developed mentholatum ointment to relieve pain in the USA in 1889. Marketing director Bernice Simpson Diabate (pictured) tells C+D about the company's products and plans following a £10 million investment in its manufacturing facility in East Kilbride.

Q What are Mentholatum's key pharmacy brands?

There's Deep Relief, Deep Heat and Deep Freeze, Regenovex, Bionovex oil, the OXY range, and Rohto Dry Eye Relief.

Q What market share do these brands have?

Mentholatum leads the topical analgesics category (all figures IRI, 52 weeks to April 17, 2010). It has three brands – Deep Heat, Deep Freeze and Deep Relief – in the top 10 and has the largest category share in the rub, spray and patch sub-sectors for both heat and freeze products.

Deep Heat is the number one topical analgesics brand, growing at 5 per cent year on year. While the rubs sector overall shows a decline of 1.9 per cent, Deep Heat bucks the trend with growth in all outlets and a 60 per cent share of the total market. It accounts for 78 per cent of value sales in major grocery multiples and 52 per cent in the pharmacy sector.

Deep Heat Spray dominates its sub-category, with 81 per cent of total market share, which equates to 93 per cent of value sales in major grocery multiples and 68 per cent in pharmacy.

Deep Heat and Deep Freeze patches together have 22 per cent share of the total market in the patch sub-category.

Q How are you investing in these brands?

All the above brands have above-the-line investment and pharmacy support programmes (OXY coming soon). Deep Heat, Deep Freeze and Deep Relief are supported by TV campaigns and consumer and trade PR.

Regenovex has been underpinned by consumer press and PR and will shortly be supported by a TV campaign.

Response beta will be supported by press and PR this year and OXY will have both TV and PR support to explain the reformulation and clinical trial data.

Q What product developments are in the pipeline?

We are working on a number of products that reflect the ethos of innovation in terms of formulations and scientific support. Regenovex, Rohto Dry Eye Relief and Response beta are our most recent launches, but there is more exciting news to come.

Q Is scientific backing important in building credibility for OTC brands?

Mentholatum is working with a number of Scottish universities to both develop new products and also test and develop scientific data and support for new and existing brands. It is committed to developing more scientific support for brands such as Deep Heat, Deep Freeze and Deep Relief, positioning the company as experts in muscle and joint care.

We are also working with a Welsh university to generate more support data on Rohto Dry Eye Relief and there is clinical work being carried out in Italy that will be delivered at the end of this year to add further weight to the brand's efficacy.

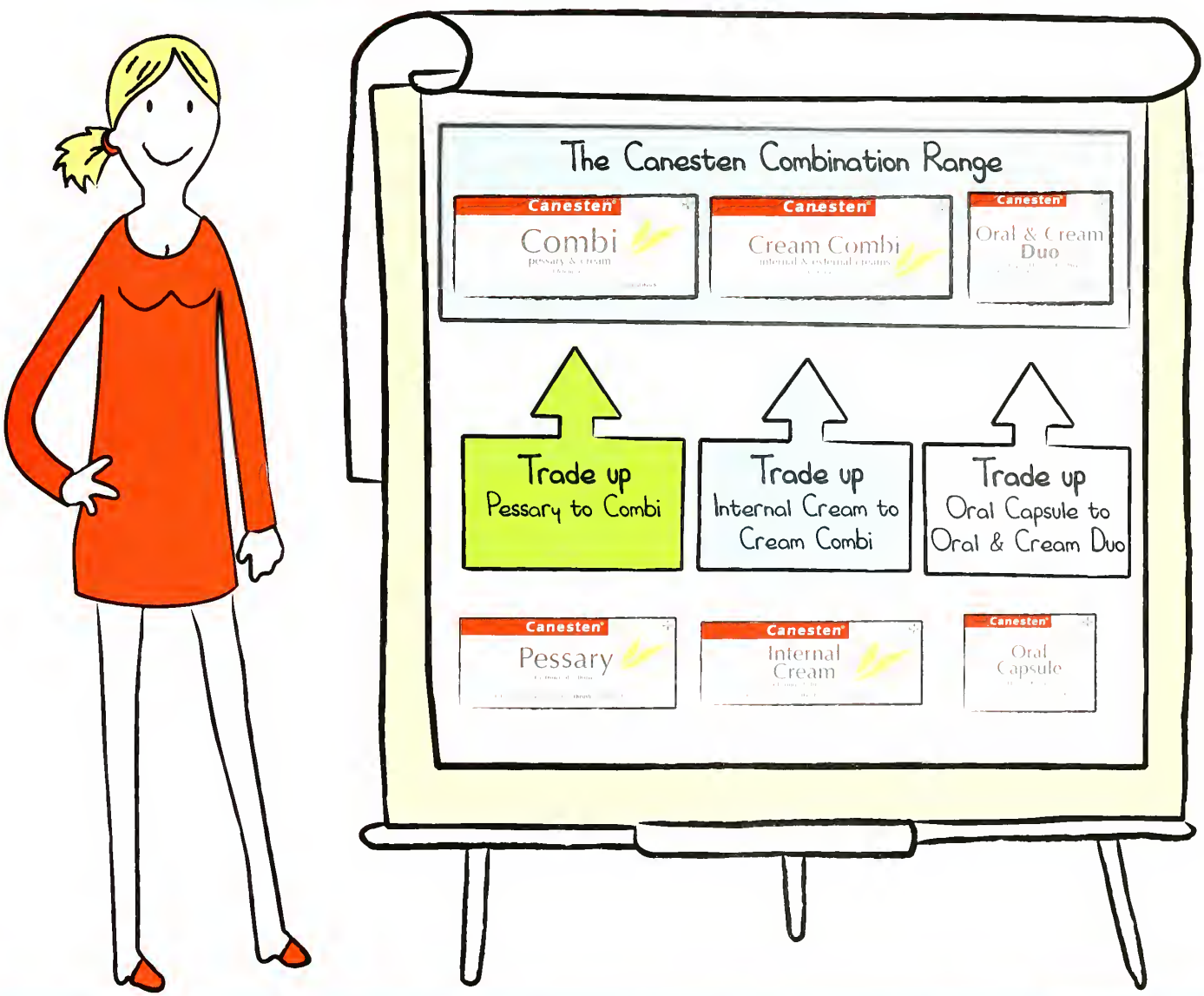
Mentholatum is absolutely committed to supporting its products with clinical and scientific data and there is no doubt that this is the cornerstone of OTC brand credibility.

Andrew Tasker, Mentholatum MD, talks growth, innnovation and your sales opportunities

www.chemistanddruggist.co.uk

Canesten®

Trade up your customers to Canesten Combination treatments



Thrush is an internal infection, but customers often present with external symptoms too.

BAYER

For more information on the Canesten range please visit the Canesten website at **www.canesten.co.uk/hcp**

CGY124 June 2010

Complete the Stock Survey online at:
www.chemistanddruggist.co.uk

Stock Survey 2010

Last year our Stock Survey uncovered a sector facing persistent medicine shortages and anxious over the impact on patient safety. So one year on has the situation improved? Help us to find out by completing and returning this questionnaire by August 4

1. On average how long do you spend trying to get hold of out of stock drugs each week?
a) Less than an hour ❒
b) 1-2hours ❒
c) 2-5 hours ❒
d) 5 hours + ❒

2. How many drugs are currently out of stock at your wholesaler?
a) 0 ❒
b) 1-5 ❒
c) 5-20 ❒
d) 20-50 ❒
e) 50+ ❒

3. Typically how long do you have to wait for an emergency stock delivery when ordered direct from a manufacturer?
a) 1-2 days ❒
b) 3 days ❒
c) 4-5 days ❒
d) Over 5 days ❒

4. How have you found getting hold of branded medicines in the past 12 months compared to the year before?
a) No different ❒
b) Easier – there are fewer drugs out of stock now than in 2008-09 ❒
c) Harder – there are more drugs out of stock than ever before ❒

5. Has it been easier or harder getting hold of product from manufacturers running reduced wholesaler distribution models?
a) Easier ❒
b) Harder ❒
c) Same ❒

6. Have you ever asked a GP to change a prescription because of problems sourcing the drug in question?
a) Yes ❒
b) No ❒

7. How concerned are you that patients are being adversely affected by stock shortages?
a) Very concerned ❒
b) Concerns, but not overly worried ❒
c) Not worried ❒

8. How many patients have you had to turn away because you have been unable to source the drug they've been prescribed?
a) 0 ❒
b) 1-5 ❒
c) 5-20 ❒
d) 20+ ❒

Win an iPod Shuffle

Complete the survey and be entered into a draw for a chance to win an iPod Shuffle!

9. Have you known a patient whose health suffered because you were having difficulty sourcing a branded drug?
a) Yes – please provide details ❒

.....

.....

b) No ❒

10. How would you rate industry and government efforts to sort shortages in the past 12 months?
a) Highly effective ❒
b) OK – they've tried hard but with limited success ❒
c) Poor – they haven't done enough ❒

11. Over the next 12 months do you expect stock shortages to be:
a) Much worse ❒
b) Slightly worse ❒
c) Stay the same ❒
d) Slightly better ❒
e) Much better ❒

Your name: _____

Pharmacy name and address: _____

_____

_____ **Postcode:** _____

Email address: _____ **Daytime phone number:** _____

Post this completed page to: Stock Survey, C+D, Ludgate House, 245 Blackfriars Road, London SE1 9UY.
All complete entries will be put into a draw for a chance to win an iPod Shuffle

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PIP Code - Unichem & Phoenix Codes	AAH code	Product Name and Description	Most Commonly Prescribed UK Brand[1]	Blister Pack Size
355-7923	RIG421N	Rigevidon® Coated Tablets Ethinylestradiol 30mcg & Levonorgestrel 150mcg	Microgynon® *(Bayer plc.)*	63's (3 x 21)
355-9275	GED1A	Gedarel® 20/150 mcg Film-coated Tablets Ethinylestradiol 20mcg & Desogestrel 150mcg	Mercilon® *(Schering-Plough Ltd.)*	63's (3 x 21)
355-9309	GED2T	Gedarel® 30/150 mcg Film-coated Tablets Ethinylestradiol 30mcg & Desogestrel 150mcg	Marvelon® *(Schering-Plough Ltd.)*	63's (3 x 21)
355-9259	MIL551F	Millinette® 20/75 mcg Coated Tablets Ethinylestradiol 20mcg & Gestodene 75mcg	Femodette® *(Bayer plc.)*	63's (3 x 21)
355-9267	MIL550J	Millinette® 30/75 mcg Coated Tablets Ethinylestradiol 30mcg & Gestodene 75mcg	Femodene® *(Bayer plc.)*	63's (3 x 21)
355-9465	TRI816B	TriRegol® Coated Tablets Ethinylestradiol 30mcg & Levonorgestrel 50mcg Ethinylestradiol 40mcg & Levonorgestrel 75mcg Ethinylestradiol 30mcg & Levonorgestrel 125mcg	Logynon® *(Bayer plc.)*	63's (3 x 21)

Rigevidon®, Gedarel®, Millinette® and TriRegol® are registered trademarks of Consilient Health Limited and Gedeon Richter Plc. Reference 1: Data on file based on 2009 PCA data

For further information for healthcare professionals and patients, please visit

www.knowyourcontraceptives.co.uk

Know your Contraceptives

Combined Oral Contraceptive Pills

Abbreviated Prescribing Information - for full prescribing information, including side effects, precautions and contra-indications, see Summary of Product Characteristics (SmPC)

Prescribing Information: Product Name: Rigevidon Coated Tablets. Composition: One tablet contains 30 micrograms ethinylestradiol and 150 micrograms levonorgestrel. **Gedarel 30/150 Coated Tablets. Composition:** 1 tablet contains 30 micrograms ethinylestradiol and 150 micrograms desogestrel **Gedarel 20/150 Coated Tablets. Composition:** 1 tablet contains 20 micrograms ethinylestradiol and 150 micrograms desogestrel. **Millinette 30/75 Coated Tablets. Composition:** 1 tablet contains 30 micrograms ethinylestradiol and 75 micrograms gestodene. **Millinette 20/75 Coated Tablets. Composition:** One tablet contains 20 micrograms ethinylestradiol and 75 micrograms gestodene. **TriRegol Coated Tablets. Composition:** Each pink tablet contains 30 micrograms ethinylestradiol and 50 micrograms levonorgestrel; each white tablet contains 40 micrograms ethinylestradiol and 75 micrograms levonorgestrel, each ochre tablet contains 30 micrograms ethinylestradiol and 125 micrograms levonorgestrel. Please refer to the Summary of Product Characteristics (SmPC) for a full list of excipients. **Indication:** Oral contraception. **Dosage and Administration:** One tablet is to be taken daily for 21 consecutive days, starting on day 1 of the normal cycle. Every subsequent pack is started after a 7-day tablet free interval, during which time a withdrawal bleed usually occurs. Bleeding usually starts on the 2nd or 3rd day after the last tablet and may not end before the next pack is started. For details of usage, especially where a patient either misses a dose or has vomiting/diarrhoea, please refer to the SmPC.

Contraindications: Combined oral contraceptives (COCs) should not be used in the presence or a history of venous or arterial thrombosis, including pulmonary embolism and myocardial infarction (MI), previous prodromal symptoms of thrombosis, including transient cerebral ischaemia, considerable or multiple risk factors for venous or arterial thrombosis or a predisposition to either condition (please refer to SmPC), cardiovascular disorders, ocular disorders of vascular origin, severe hypertension, diabetes complicated with angiopathy, cerebrovascular disorder or accident, migraine with focal neurology, pancreatitis with severe hypertriglyceridaemia, severe or recent hepatic disorders, liver tumours, undiagnosed vaginal bleeding, sex steroid influenced malignancies, e.g. breast and endometrial, or a hypersensitivity to the components of the tablet.

Warnings and Precautions: Prior to starting or resuming use a complete history should be taken, a physical examination performed and pregnancy ruled out. The patient should be instructed to carefully read the user leaflet and adhere to the advice. The benefits of COC use must be weighed against possible risks and discussed with the patient with respect to the following conditions: venous or arterial thromboembolism, MI or transient ischaemic attack/stroke. Patients who develop an increase in frequency or severity of migraine should discontinue COC use. A possible increased risk of cervical cancer has been reported with all long-term COC use. Please refer to the SmPC for associated risk factors and symptomology associated with the above conditions. Breast cancer has been reported in COC users, though no direct causation has been shown; clinically relevant increases in blood pressure (rare), hepatic tumours and pancreatitis in the presence of or with a family history of hypertriglyceridaemia have also been reported. Patients who develop severe depression during the use of COCs should discontinue use and be advised to use an alternative contraceptive method until the cause is identified. COC should also be stopped in women with impaired liver function until tests return to normal. Please refer to the SmPC for other conditions that have been reported with COC usage. With all COCs, irregular bleeding may occur, especially during the first months of use. The evaluation of any irregular bleeding should be considered after approximately three cycles. If bleeding irregularities occur after previously regular cycles, further diagnostic procedures should be considered. Please refer to the SmPC for further information regarding cycle control.

Pregnancy and lactation: The COCs are not indicated during pregnancy; treatment should be withdrawn immediately if pregnancy occurs. The use of COCs is not recommended during breast feeding. **Effects on ability to drive and use machinery:** There is no influence on the ability to drive and use machines. **Undesirable effects:** The following adverse reactions have been reported in women using COCs: *Very common* (≥ 1/10): irregular bleeding, nausea, weight increase, breast tenderness and headache. These usually occur at the beginning of treatment and are transient. *Other common* (≥ 1/100, < 1/10): fluid retention, changes to libido, irritability, migraine, acne, amenorrhoea, hypomenorrhoea, dysmenorrhoea, metrorrhagia, nervousness, mood changes including depression, dizziness, ocular irritation in contact lens wearers, visual disturbance, corneal disorders, abdominal pain, breast enlargement or secretion, changes in cervical ectropion and secretion, vomiting, cholelithiasis and chloasma. Venous and arterial thromboembolic disorders, cervical cancer, liver tumours and chloasma have also been reported with COC use. Please see SmPC for other adverse events associated with COC use. **Overdose:** There have been no reports of serious adverse effects from overdose. **NHS Price: Rigevidon** 3 x 21 tablets £1.89, **Gedarel 30/150** 3 x 21 tablets £4.93, **Gedarel 20/150** 3 x 21 tablets £5.98, **Millinette 30/75** 3 x 21 tablets £4.85, **Millinette 20/75** 3 x 21 tablets £6.37, **TriRegol** 3 x 21 tablets: £2.87.

Legal category: All POM. **Authorisation numbers: Rigevidon** PL 17550/0032, **Gedarel 30/150** PL 04854/0061, **Gedarel 20/150** PL 04854/0060, **Millinette 30/75** PL 17550/0043, **Millinette 20/75** PL 17550/0044, **TriRegol** PL 17550/0031. **Marketing Authorisation Holder: Rigevidon, Millinette, TriRegol** Medimpex France SA, 1 - 3 rue Caumartin, 75009 Paris, France. **Gedarel** Gedeon Richter Plc, 1103 Budapest, Gyomroi ut, 19-21, Hungary. **Date of Authorisation:** Rigevidon October 2007, Gedarel 26.11.2008, Millinette 28.05.2009, TriRegol 20.06.2007. Further information is available on request from Consilient Health (UK) Ltd, 500 Chiswick High Road, London, W4 5RG, UK on 020 8956 2310.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Consilient Health (UK) Ltd, 500 Chiswick High Road, London, W4 5RG, UK on 020 8956 2310.

Available now from Consilient Health and National Wholesalers

Date of preparation: June 2010. [illegible]

We need a Mary Portas-style shake-up

"AN AREA MANAGER TOLD A FRIEND TO GET THE DEAD FLIES OUT OF THE WINDOW OR PUT A PRICE ON THEM"

Occasionally there are some very odd customers through the door. I don't just mean the Mrs Malaprops asking for coleslaw lotion or diuretic jam, I mean those OTC queries that seem just a bit too pat, and you wonder if you've been visited by an undercover Which? reporter, or worse – you've been 'mystery shopped'.

It's a while since I worked for a pharmacy multiple, so I'd rather forgotten the mystery shopper. The best part was looking at their comments and trying to work out who they spoke to – a blame-game referred to as 'pin the tail on the donkey'. Even our PCT got with the programme and tried mystery shopping the EHC services – the results of this were never released, but I understand some pharmacies received invitations for additional training...

Of course no one likes someone checking up on them and being put under the spotlight. Surveys of shop workers regularly put the mystery shopper as one of their greatest fears, and yet patient surveys are not seen as something to fear – simply a chore – and that alone demonstrates what a pointless chore they are.

When asked "How do you rate us?", patients are bound to mark something better than average because either they are being polite, or they want to get it over and done with, or they fear we will have a sneaky look at what they've put. The only people who don't are those who are annoyed because we're too busy – and then we're too busy to ask them to complete a survey anyway. So what does the survey tell us? Nothing of use.

A while ago, an NPA friend asked if I fancied having Mary Portas come round. If you are not familiar with this lady, you can catch her TV programme on Monday nights, where she acts as a sort of troubleshooter on high street shops. Having been approached by her production company for a pharmacy, and realising that a well-run, ethical, presentable, go-ahead, professional pharmacy wouldn't make good TV, the NPA feared the worst – we can all think of somewhere locally that would make great TV but we wouldn't want to be the national face of pharmacy.

Yet without a truly critical eye, how do we improve? Who is to notice the broken light bulb that didn't get fixed? A good area manager once told a friend of mine to "get the dead flies out of the window, or put a price on them", but we don't all have the opportunity to receive such wisdom.

Perhaps we do need Mary Portas to shake us up, not just individually but as a profession. As we chase ever more additional services, the most common weak point in the patient survey is "lack of private, quiet, area for consultation" – even when the patient is completing the survey while sitting opposite our purpose-built, signposted, consultation room!

How many more perceptions has the professional to overcome? Let's hope that won't stay a complete mystery.

Where was RPSGB during Lee prosecution?

Once an appeal judge gave Elizabeth Lee permission to appeal against her conviction and sentence, the outcome was entirely predictable.

The Court of Appeal has now given its reasons for overturning the conviction for a labelling error (because the offence could only be committed if Mrs Lee was running a pharmacy business) and substituting a conviction for supplying the wrong medication – an offence that did not require the defendant to be running a pharmacy business.

There are still loose ends, such as the decriminalising of dispensing errors. This remains a thorn in the side of pharmacists and – don't forget – dispensers also can and have been prosecuted.

In my opinion it was inevitable that Mrs Lee's suspended sentence would be overturned. The Court of Appeal was bound to conclude that this was manifestly excessive.

The prosecution had pressed for the case to be sent to the Crown Court (the Old Bailey is technically a Crown Court) and the Court of Appeal rightly pointed out that the case should normally have been dealt with in the Magistrates Court.

On conviction, the maximum fine magistrates could have imposed was £5,000. When deciding on the level of fine, the Court of Appeal took into account the effect on the patient's family. That's a perfectly permissible consideration these days, though personally I think it's important to make sure revenge is not allowed to feature in our justice system. The court took into account Mrs Lee's good character and said it would have imposed a fine of £400.

However, because Mrs Lee pleaded guilty, the fine was reduced to £300. This compares well with the fatal Peppermint Water case 10 years ago, when a pharmacist was fined £1,000 and a pre-reg student was fined £750, and a case in 2009 in which a pharmacist was fined £2,065, and a dispensing assistant was fined £270.

There are professional disciplinary procedures to deal with dispensing errors that might involve misconduct, so the CPS should not have brought a case that merited a fine of only £400. But the CPS doesn't deserve all the blame. The Royal Pharmaceutical Society has always had power to prosecute for offences under the Medicines Act.

The Society should have a better understanding than the CPS of whether a case merits prosecution, but the Society stopped bringing prosecutions a long time ago. The Society's abdication of responsibility left a vacuum that the less well-informed CPS has filled.

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"THE SOCIETY'S ABDICATION OF RESPONSIBILITY LEFT A VACUUM THAT THE LESS WELL-INFORMED CPS HAS FILLED"

Letters

Contact us

Email your letters, including your name, address and contact number, to **haveyoursay@chemistanddruggist.co.uk**

Four months to decide pharmacy's future

The current government budget crisis could be turned from a threat facing community pharmacy into an opportunity.

The opportunity to influence will only exist between now and the departmental spending review in October: after that influencing how and where the health budget is spent will become exponentially more difficult.

I suggest four things that need to happen urgently.

Firstly, the bodies that represent community pharmacy in England need to join forces under a single banner with an agreed set of messages.

Secondly, those bodies need to fund a joint professional lobbying campaign focused on influencing the outcome of the spending review. As part of that, there has to be a clear focus on influencing treasury ministers and officials as ultimately they are the ones who decide what gets funded and what does not.

Ironically perhaps, treasury ministers and officials may be more likely to listen to pharmacy's case than their counterparts at the Department of Health (DH).

A critical part of that campaign will be to produce a persuasive position paper that sets out the economic case for community pharmacy to play a stronger role in providing primary care services.

Let's just accept that the benefits to patients are obvious: the argument will be won or lost on questions about cost savings and getting the same or better patient outcomes for less NHS spend.

There is lots of evidence out there – for example the recent 2020health think tank report that suggested the DH could save £1.6 billion if minor ailments were to be commissioned through pharmacies – so let's pull all the evidence together and present the government with a big £ that will get their attention. How much would the NHS save if it avoided the hugely costly secondary care interventions that result from medicines non-adherence?

Mark James: AAH will back united campaign

Thirdly, we need a campaign that is not about getting the 'support' of MPs: instead it is about getting them to act. Unless they are tabling questions, writing letters to the minister, tabling early day motions, or initiating debates then there will be no pressure from the Commons on health and treasury ministers to listen to pharmacy's case.

Finally, we need an approach that does not provoke opposition from GPs. Not easy to achieve, but necessary nonetheless.

We need to shift the way people think about this debate. Instead of putting forward a justification for the government to commission more services from pharmacy, we need a campaign that says – given the current budget crisis and the pressures facing the NHS – how could the government justify not commissioning more services from community pharmacy.

If you combine the contacts and resources of pharmacy bodies and individual companies such as Boots and Lloydspharmacy etc, you have a strong force, but it needs a shared direction and a joint plan of action.

If such a campaign could be launched I assure you we will back it with our lobbying contacts and resources. I am sure other wholesalers would do likewise.

Mark James, group managing director, AAH

Give us the chance to show you what pharmacy can achieve

As a result of the budget we are all coming to terms with the personal and business implications of spending cuts and taxation changes.

We remain uncertain of what the coalition government's specific plans are for the NHS and how much pharmacy will feature. Of course there's always the thought that it may mean a heavier workload, but if we are not involved what does that say about our profession and industry and sustainability for the future? It's easy to be disheartened but we should not lose sight of the good work that pharmacy continues to do for its patients.

Despite the general doom and gloom, I have been inspired by two very recent events, which I was fortunate to be part of.

Firstly, I was involved in selecting the best pre-registration student training on the Numark pre-registration programme. Fifty nine students participated in a health promotion event in their pharmacy to improve the pharmacy's public health remit. As you would probably expect, there were some very obvious choices in topics such as stop smoking, weight management, diabetes screening. There is nothing wrong with that and it does fit into the government's priorities for public health. However, what struck me was the amount of work that the students put in to planning their event, marketing, delivering and extracting the learnings from it to refine their service.

Mimi Lau: innovative pharmacy projects show what the sector can do

All these initiatives had the wholehearted support of the pharmacist tutors as well as the staff working in the various pharmacies. There were also examples of pure innovation, such as the Stamford Bridge walk project. This pharmacy used a simple but effective campaign to increase the activity levels of the community through organising weekly walks around the village.

Another example was a project on smoking cessation whereby the pharmacy engaged with Tower Hamlet PCT to reach out into the transient community. People coming out of the nearby tube station were targeted and the pre-reg spread the message of smoking hazards and signposted the pharmacy for advice and support on quitting.

Many of these projects have become fully fledged services, which is an excellent achievement for the students as well as the pharmacy team. We have also gone on to share the success of these projects throughout our organisation so that other pharmacies are inspired and motivated to do something similar.

The second event was last month's C+D Awards. Seeing so much excellence in the work being done by individuals, teams and businesses is fantastic and proof that it's not just the young or newly qualified that have great ideas. It may often be seen as 'part of our day job', but we should celebrate success and let our paymasters know the worth in investing in pharmacy.

So ministers, commissioners, if you are reading this, please take note – don't isolate our profession, there is much we offer now to our patients and there is still more we can offer if you give us the chance.

Mimi Lau, director of professional and training services, Numark

Update

Your weekly CPD revision guide

Module 15.4

Managing rheumatoid arthritis

In the second of two articles on rheumatoid arthritis, we reveal how modern treatment takes an aggressive approach to limiting disease progression

60-second summary

As well as pain control, treatment aims to limit joint damage. But the agents used have a host of potential problems, so use this article as CPD to remind yourself of the care patients might need

Why must treatment start early?

To minimise long-term damage to the joints. DMARDs dampen inflammatory immune activity in the joints, while the biologics inhibit TNF-alpha, a key culprit in joint damage. Nice recommends starting DMARD combination treatment within three months of onset of persistent symptoms followed by TNF-alpha inhibitors if active RA fails to respond.

What about pain control?

Paracetamol has a good safety profile, but opioids are likely to be needed. Nice recommends NSAIDs, but they must be used with care.

To get updates emailed to you each week, register for C+D's CPD newsletter at www.chemistanddruggist.co.uk/register

Helen Boreham

Treatment in rheumatoid arthritis (RA) used to be centred on pain relief – but disease-modifying anti-rheumatic drugs (DMARDs) and targeted biological agents now provide powerful disease suppression. These days, therefore, the management of RA addresses both the symptoms and the underlying disease process.

Drug therapy

Four main types of drugs are used to treat RA:[1]

- analgesics
- non-steroidal anti-inflammatory drugs (NSAIDs)
- disease-modifying anti-rheumatic drugs (DMARDs)
- corticosteroids.

Simple analgesics such as paracetamol rarely offer enough pain relief to be used as monotherapy but can be a valuable adjunct to combination therapy with more powerful opioid analgesics such as codeine or tramadol. NSAIDs, including over the counter options, are widely used to relieve day-to-day pain and stiffness.

DMARDs target the underlying disease processes in RA and are the lynchpin of current treatment. They are not painkillers and can take weeks or even months to show an effect. DMARDs improve symptoms by dampening down the inflammatory immune activity in the joints and, if taken early enough, can reduce long-term joint and bone damage and improve functional outcomes.

Key DMARDs include:

- methotrexate, an antimetabolite that inhibits the metabolism of folic acid, is usually the first choice DMARD for RA
- sulfasalazine is also used to treat inflammatory bowel disease and is often prescribed in combination regimens with methotrexate or other DMARDs
- gold is usually given as deep intramuscular injections of sodium aurothiomalate, which accumulates slowly in the body and reduces inflammation
- penicillamine is a metabolite of pencillin that exerts immunosuppressive effects
- hydroxychloroquine, an antimalarial drug, is usually prescribed for RA where inflammatory activity is moderate.

Other disease-modifiers such as azathioprine, ciclosporin, cyclophosphamide and leflunomide are considered more toxic and generally reserved for cases that have not responded to other DMARDs.[2]

The so-called 'biologics' are specifically designed to target aberrant cytokine responses seen in RA. These drugs effectively inhibit TNF-alpha – a pro-inflammatory mediator that has been pinpointed as one of the major molecules involved in the pathogenesis of RA and a key culprit in joint damage. To be eligible, patients must have active RA that has failed to respond to, or tolerate, standard DMARD treatment, including methotrexate.

Concerns and contraindications

Analgesics and NSAIDs

- Paracetamol has a sound safety profile with a low risk of side effects, no significant drug interactions (apart from warfarin) and is suitable for use in most concomitant conditions.
- Caution should be exercised when giving NSAIDs to elderly patients and those with allergic disorders, coagulation defects, renal, cardiac or hepatic impairment, and asthma. Use Cox-2s with caution where there is a history of cardiac failure, left ventricular dysfunction, hypertension, oedema or risk factors for heart disease.
- All NSAIDs are contraindicated in severe heart failure. Conventional NSAIDs are also contraindicated in patients with previous or active peptic ulcers. Cox-2s must not be given to patients with ischaemic heart disease, cerebrovascular disease, peripheral arterial disease, moderate or severe heart failure or active ulceration.
- The main side effects of NSAIDs include gastro-intestinal disturbances, nausea, diarrhoea, GI bleeding and ulceration, and potential hypersensitivity reactions.
- NSAIDs also have a range of interactions, which are listed in the BNF.

Methotrexate

- Methotrexate[2,3] can affect blood count (via bone marrow suppression) and cause liver cirrhosis (even at low doses) and pulmonary toxicity. Regular monitoring is needed throughout treatment and patients should be counselled to report all signs and symptoms suggestive of infection – especially sore throat.
- Methotrexate should be used with caution in patients with blood disorders, peptic ulceration, ulcerative colitis, diarrhoea and ulcerative stomatitis, pleural effusion or ascites, and acute porphyria.
- Methotrexate is contraindicated in active infection and immunodeficiency syndromes, hepatic and severe renal impairment, liver disease, pregnancy and breastfeeding.
- Aspirin and other NSAIDs reduce methotrexate excretion, so careful dose monitoring of the latter

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* Source: Neilsen: Total Chemists MAT Value & Unit Sales (11.12.09)

is needed if these medicines are used together. Patients on methotrexate should avoid self-medication with OTC aspirin, ibuprofen or diclofenac. Methotrexate also interacts with a range of drugs – see the BNF for the full list. Interaction with alcohol raises the risk of liver damage so intake should be limited or avoided while on methotrexate.

- Because methotrexate is teratogenic, effective contraception is required in both men and women during treatment, and for a further three months.
- The most common side effects of methotrexate are rash, itching, photosensitivity, mouth ulcers, chest pain, breathing problems, nausea, vomiting, diarrhoea, headaches, drowsiness and blurred vision. Folic acid, which is often co-prescribed with methotrexate, can reduce the severity of side effects.

Sulfasalazine

- Sulfasalazine[2,3] should be used with caution in patients with a history of allergy or asthma, G6PD deficiency, slow acetylator status, acute porphyria, renal and hepatic impairment, pregnancy and breast-feeding. It is contraindicated in sulphonamide hypersensitivity and severe renal impairment.
- Side effects include rashes, gastrointestinal intolerance and occasional leucopenia, neutropenia and thrombocytopenia. Close monitoring of full blood counts is necessary until therapy is stabilised.
- Possible drug interactions are digoxin, folic acid, azathioprine and mercaptopurine.
- Good fluid intake is essential while on sulfasalazine – patients should be encouraged to drink six to eight glasses of water a day.

Sodium aurothiomalate

- Gold[2] is contraindicated in people with a history of blood disorders or bone marrow aplasia, exfoliative dermatitis, lupus, necrotising enterocolitis, pulmonary fibrosis, severe kidney and liver dysfunction and acute porphyria. Caution should also be applied in mild-to-moderate hepatic and renal impairment, pregnancy and breastfeeding, elderly patients and those with a history of urticaria, eczema or colitis.
- Side effects of gold include severe anaphylactic reactions, stomatitis, taste disturbances, colitis, hepatotoxicity with cholestatic jaundice, pulmonary fibrosis, peripheral neuropathy, mouth ulcers, proteinuria, blood disorders, nephrotic syndrome, gold deposits in the eye, alopecia and skin reactions.
- Gold interacts with penicillamine.

Penicillamine

- Penicillamine[2,3] should be used cautiously in renal impairment, pregnancy and breastfeeding and in patients receiving concomitant nephrotoxic drugs or gold. Regular blood counts and urine tests are needed. Penicillamine is expressly contra-indicated in lupus.
- Common side effects include nausea and vomiting, loss of appetite, loss of taste and rash.
- Penicillamine interacts with antacids, clozapine, digoxin, gold, iron, NSAIDs and zinc.

Hydroxychloroquine

- Caution should be exercised in patients with neurological disorders (especially epilepsy), severe gastrointestinal problems, G6PD deficiency, moderate-to-severe hepatic impairment, pregnancy, acute porphyria and in the elderly. Hydroxychloroquine[2,3] may exacerbate psoriasis and aggravate myasthenia gravis. Regular ophthalmological check-ups are recommended because of the potential (albeit rare) risk of retinopathy. More common side effects include upset stomach, headache, skin rashes and itching.
- Concurrent use of hepatotoxic drugs should be avoided. There are also significant interactions with other drugs – see the BNF for a full list.

Nice guidelines

Nice[4] advises that intervention in RA should be early and efficacious. This aggressive approach to pharmacotherapy is based on clear clinical evidence showing a 'window of opportunity' for preventing inflammation-induced structural damage to joints. In newly-diagnosed active RA, DMARD combination therapy is recommended as first-line treatment – to be started as soon as possible and preferably within three months of the onset of persistent symptoms. This should include methotrexate and at least one other DMARD, plus short-term glucocorticoids. Once the disease is stable, doses can be cautiously reduced to levels that maintain disease control, but with re-escalation at the first sign of flare.

When introducing drugs to boost disease control, it may be possible to decrease or stop pre-existing medication if the new therapy is successful. However, prompt review is needed whenever DMARD or biologic doses are decreased or stopped. For new patients in whom DMARD combination therapy is not appropriate, Nice advises starting with monotherapy and concentrating on fast escalation to a clinically effective dose.

The TNF-alpha inhibitors adalimumab, etanercept, infliximab and certolizumab pegol are options for active RA that has failed to respond to at least two DMARDs, including methotrexate (unless contraindicated).[2] Biologics should ideally be given in combination with methotrexate; however, when methotrexate cannot be used because of intolerance or contraindications, adalimumab or etanercept can be given as monotherapy.[2] Anakinra, another biologic cytokine modulator, is licensed for RA but not recommended by Nice for routine treatment.

Nice has recently published a new draft guideline that changes its stance on refractory RA. Although previously rejected on cost grounds, tocilizumab is now recommended in combination with methotrexate in moderate to severe active RA and can be used in patients whose disease has responded inadequately to one or more TNF-alpha inhibitors and rituximab (or in whom rituximab is contraindicated or withdrawn due to adverse effects). Nice has also lifted earlier restrictions on anti-TNF use. Patients who fail to respond (or stop responding) to a first TNF-alpha inhibitor will now have the option of trying a second anti-TNF agent. (See individual Nice guidelines on each biologic for specific details of their place in therapy.)

Nice suggests symptom control with analgesics should be offered to all patients with inadequate pain control. Standard NSAIDs or Cox-2s are to be offered as first choice, co-prescribed with a proton pump inhibitor and given at the lowest effective dose for the shortest possible time. Because of the potential gastrointestinal, liver and cardiorenal toxicity with NSAIDs and Cox-2 inhibitors, it is important to:

- consider individual patient risk factors, including age, when choosing drug and dose
- assess and/or monitor patient risk factors
- consider other analgesics if the patient is already taking low-dose aspirin for other conditions.

In cases where analgesics fail to offer satisfactory symptom control, the DMARD or biologic regimen should be re-examined. Glucocorticoids can be useful short-term treatment for flares or as an additional element to DMARD combination therapy. However, their long-term use in established RA is restricted to cases where all other treatments have been tried, and providing complications have been fully discussed.

Nice stresses the importance of co-ordinating RA management within a multidisciplinary healthcare team in order to maximise outcomes for patients.

Self help

Self care is a key element to overall RA management, with a focus on protecting and preserving joint function. To this end, patients should be advised to:

- balance rest and exercise
- avoid contact sports and high impact activities – swimming is one of the best activities for RA
- wear exercise shoes with thick soles to help absorb shocks
- protect joints from unnecessary strain. Joint-sparing techniques can be found on the Arthritis Research UK website
- keep weight under control.

Nice insists there is no strong evidence dietary changes can benefit patients.[4] However, a Mediterranean-style diet is to be encouraged on the basis of its low saturated fat content and high intake of healthy unsaturated fats such as fish oils.[4] In a recent scientific review of anti-arthritis supplements, fish body oils were given the top efficacy rating of 5 out of 5 based on good evidence supporting their ability to reduce RA symptoms.[5] There is also some evidence that combined treatment with fish body and liver oils may be of long-term benefit, allowing the daily requirement for NSAIDs to be reduced.[5]

References are available in the full version of this article at www.chemistanddruggist.co.uk/update

Helen Boreham is a freelance medical writer with an MSci in medicinal chemistry.

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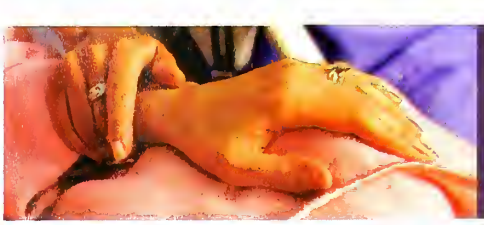

NEXT WEEK
Update looks at pain control in palliative care

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References 1 GSK data on file 2010 (visceral fat study) 2 World HealthOrganisation The challenge of obesity in the WHO European region and the strategies for response 2007 Available at www.euro.who.int/document/E89858.pdf Accessed 14/1/10

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Rheumatoid arthritis: part 2

What are the side effects of methotrexate? Why should patients taking hydroxychloroquine have regular eye check ups? What does Nice recommend for the treatment of RA in a newly diagnosed patient?

This article describes the management of rheumatoid arthritis and the drug therapy used. There is information about analgesics, NSAIDs, DMARDs and corticosteroids, how they work, side effects and contraindications. The Nice guidelines and self help are also discussed.

- Update your knowledge of the Nice guidelines for the management of rheumatoid arthritis in adults at http://tinyurl.com/rheumatoid4.
- Find out more information about DMARDs from the Patient UK website at http://tinyurl.com/rheumatoid5.
- More information about the prescribing of drugs for RA can be found in section 10.1.3 in the BNF.
- Think about the advice you could give about RA medication in an MUR. What lifestyle advice could you give? The National Rheumatoid Arthritis Society has a list of tips for sufferers at http://tinyurl.com/rheumatoid6 that your patients may find useful.

Are you now familiar with the management of RA? Are you confident in your knowledge of the side effects and contraindications of the drugs used? Could you give lifestyle advise to RA patients?

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Practical Approach

How do you recognise cannabis addiction?

At home one evening David Spencer, pharmacist at the Update Pharmacy, gets a telephone call from his friend Barry, who sounds worried.

Barry says: "David, do you know how to tell if someone is using cannabis?"

"Can I ask why you want to know?" replies David.

"It's my son, Simon. You know we've had some problems with him. He dropped out of college, hasn't got a job, doesn't seem to have many friends and spends most of his time loafing about at home."

"So, what makes you think he might be using cannabis?"

"Firstly, it's the smell in his room. I'm pretty sure that he's been smoking in there but it doesn't smell like cigarettes. On top of that, he never was what you would call a lively boy, but he seems to have become even more lethargic lately. And he's always short of money and asking me for some, although he rarely goes out and I can't see what he could be spending it on. I don't know whether this has anything to do with it, but his eyes look red and bloodshot, too."

"I'm no expert," David replies, "but I think your suspicions could be right. If you want, I can put you in touch with some agencies that could either confirm or dispel your fears, and if he's addicted they could help him to get off it."

"I'd rather keep it in the family," Barry says. "I was hoping you might know how I should deal with it."

Questions

1. Could the signs Barry has listed indicate cannabis use?
2. What other tell-tale signs are there in young people?
3. What are the acute adverse effects of cannabis use?
4. What are the long-term effects?
5. What advice on the management of withdrawal could David give Barry for his son?
6. Are there any medicinal products containing cannabis licensed for use in the UK?

Answers

1. Yes.
2. Attempts to mask the smell of cannabis smoke with air freshener or incense; small burns on the thumb and forefinger; signs of depression or isolation; withdrawal from family activities; sudden drop in academic performance; abandoning previous activities and interests, eg sports, hobbies; appearing confused, slow and lethargic.
3. Anxiety, confusion, drowsiness, panic reactions, psychosis, hallucinations, psychomotor impairment; red eyes; memory loss; tachycardia, palpitations, postural hypotension, flushing; coughing, sore throat, bronchospasm (in asthma sufferers); abdominal pain, nausea, vomiting.
4. Bronchitis, possibly lung cancer; oligospermia, gynaecomastia, reduced libido; insomnia, depression, anxiety, decreased cognitive function, possibly schizophrenia.
5. Reduce use gradually before cessation; delay first use of cannabis until later in the day; advise on good sleep hygiene, including avoidance of caffeine, which may exacerbate irritability, restlessness and insomnia; try relaxation, progressive muscular relaxation and distraction.
6. Yes, Sativex, an oral spray containing Cannabis sativa extract used for the treatment of muscle stiffness in multiple sclerosis. It is now officially licensed in the UK, but has been available for several years on an open general licence from the Home Office, allowing it to be prescribed and dispensed on a named patient basis.

Reference

Winstock AR, Witton J. Assessment and management of cannabis use disorders in primary care. BMJ 2010; 340:c1571

Abbreviated Prescribing Information – Zarzio® Filgrastim. **Presentation:** 30 MU/0.5 ml and 48 MU/0.5 ml solution for injection or infusion in pre-filled syringe. **Uses:** Reduction in the duration of neutropenia and the incidence of febrile neutropenia in patients treated with established cytotoxic chemotherapy for malignancy (with the exception of chronic myeloid leukaemia and myelodysplastic syndromes) and reduction in the duration of neutropenia in patients undergoing myeloablative therapy followed by bone marrow transplantation considered to be at increased risk of prolonged severe neutropenia. Mobilisation of peripheral blood progenitor cells (PBPC). In children and adults with severe congenital, cyclic, or idiopathic neutropenia with an absolute neutrophil count (ANC) of ≤ 0.5 x 10⁹/l, and a history of severe or recurrent infections. Treatment of persistent neutropenia in patients with advanced HIV infection. Please refer to the Summary of Product Characteristics for full prescribing indications. **Administration:** Filgrastim should only be given in collaboration with appropriate and experienced specialist centres with the necessary facilities. When given by infusion, filgrastim solution must be diluted with glucose; see Summary of Product Characteristics for details. *Established cytotoxic chemotherapy:* Subcutaneous injection or intravenous infusion. *Patients treated with myeloablative therapy followed by bone marrow transplantation:* Intravenous short-term (over 30 mins) infusion or as a subcutaneous or intravenous continuous infusion over 24 hours. *Mobilisation of PBPC:* Subcutaneous injection or subcutaneous continuous infusion. *SCN/HIV infection:* Subcutaneous injection. **Dosage:** For the approved indications the typical dosage range is from 0.1 MU/kg/day to 1.2 MU/kg/day. For the detailed instructions on dosage, please refer to the SPC. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Precautions** Special warnings: Zarzio should not be used to increase the dose of cytotoxic chemotherapy beyond established posology regimens. Should not be administered to patients with severe congenital neutropenia (Kostmann's syndrome) with abnormal cytogenetics. Established cytotoxic chemotherapy: *Malignant cell growth:* Zarzio should not be administered in patients with myelodysplastic syndrome or chronic myelogenous leukaemia. Care should be taken to distinguish the diagnosis of blast transformation of chronic myeloid leukaemia from acute myeloid leukaemia. Caution should be taken in patients with secondary AML. Safety and efficacy of administration in de novo AML patients < 55 years with good cytogenetics (t(8,21), t(15;17), and inv[16]) have not been established. *Leucocytosis:* White blood cell counts should be performed at regular intervals during therapy. If leukocyte counts exceed 50 x 109/l after the expected nadir, Zarzio should be discontinued immediately. For PBPC mobilisation Zarzio should be discontinued or reduced if the leukocyte counts rise to > 70 x 109/l. *Risks associated with increased doses of chemotherapy:* Intensified doses of chemotherapeutic agents may lead to increased toxicities including cardiac, pulmonary, neurologic, and dermatologic effects (please refer to the Summary of Product Characteristics of the specific chemotherapy agents used). Regular monitoring of platelet count and haematocrit is recommended. Special care should be taken when administering single or combination chemotherapeutic agents which are known to cause severe thrombocytopenia. *Other special precautions:* In patients with reduced precursors, neutrophil response may be diminished (see SPC for details). There have been reports of Graft versus Host Disease (GvHD) and fatalities in patients receiving G-CSF after allogeneic bone marrow transplantation (refer to SPC). Mobilisation of PBPC: *Prior exposure to cytotoxic agents:* After extensive myelosuppressive therapy, Zarzio, may not show sufficient mobilisation of PBPC to achieve the recommended minimum yield or acceleration of platelet recovery (see SPC for details). *Assessment of progenitor cell yields:* Results of flow cytometric analysis of CD34+ cell numbers vary depending on the precise methodology used, therefore, recommendations of numbers based on studies in other laboratories need to be interpreted with caution. *Normal donors prior to allogeneic PBPC transplantation:* Only to be considered in normal donors for the purpose of allogeneic stem cell transplantation. Transient thrombocytopenia following Zarzio administration and leukapheresis has been observed (see SPC for further details). Zarzio should be discontinued or the dose reduced if the leukocyte counts rise to > 70 x 10⁹/l. Donors who receive G-CSFs for PBPC mobilisation should be monitored until haematological indices return to normal (see SPC for details). Transient cytogenic modifications have been observed in normal donors following G-CSF use. Spleen size should be carefully monitored. A diagnosis of splenic rupture should be considered in donors and/or patients reporting left upper abdominal pain or shoulder tip pain. *Recipients of allogeneic PBPCs mobilised with Zarzio:* Immunological interactions between the allogeneic PBPC graft and recipient may be associated with an increased risk of acute and chronic GvHD when compared with bone marrow transplantation. SCN: *Blood cell counts.* Platelet counts should be monitored closely, especially during the first few weeks therapy. Consideration should be given to intermittent cessation or decreasing the dose in patients who develop thrombocytopenia. Other blood cell changes occur, including anaemia and transient increases in myeloid progenitors, which require close monitoring of cell counts. *Transformation to leukaemia or myelodysplastic syndrome.* Special care should be taken in the diagnosis of SCNs to distinguish them from other haematopoietic disorders. Complete blood cell counts with differential and platelet counts, and an evaluation of bone marrow morphology and karyotype should be performed prior to treatment. If patients with SCN develop abnormal cytogenetics, the risks and benefits of continuing Zarzio should be carefully weighed. Zarzio should be discontinued if MDS or leukaemia occurs. It is recommended to perform morphologic and cytogenetic bone marrow examinations in patients at regular intervals (approx every 12 months). *Other special precautions:* Causes of transient neutropenia, such as viral infections should be excluded. Splenic enlargement is a direct effect of filgrastim and spleen size should be monitored regularly. Regular urine analyses should be performed to monitor haematuria/proteinuria. The safety and efficacy in neonates and patients with autoimmune neutropenia have not been established. HIV infection. *Blood cell counts:* ANC should be monitored closely, especially during the first few weeks of Zarzio therapy (see SPC for details). Risk associated with increased doses of myelosuppressive medicinal products: Regular monitoring of blood counts is recommended (see SPC for details). *Infections and malignancies causing myelosuppression:* The effects of filgrastim on neutropenia due to bone marrow-infiltrating infection or malignancy have not been well established. Other special precautions: Pulmonary adverse reactions such as interstitial pneumonia have been rarely reported following filgrastim, and patients with a recent history of pulmonary problems may be at higher risk. Monitoring of bone density may be indicated in patients with underlying osteoporotic bone diseases who undergo continuous therapy with Zarzio for more than 6 months. Physicians should exercise caution when considering the use of Zarzio in patients with sickle cell disease and carefully evaluate the potential risks and benefits of treatment. Increased haematopoietic activity of the bone marrow in response to growth factor therapy has been associated with transient positive bone-imaging findings which should be considered when interpreting such results. Zarzio contains sorbitol. Patients with rare hereditary problems of fructose intolerance should not use this medicinal product. **Interactions:** Use is not recommended in the period from 24 hours before to 24 hours after myelosuppressive cytotoxic chemotherapy. Preliminary evidence from a small number of patients treated concomitantly with filgrastim and 5-fluorouracil indicates that the severity of neutropenia may be exacerbated. Possible interactions with other haematopoietic growth factors and cytokines have not yet been investigated in clinical studies. Lithium is likely to potentiate the effect of filgrastim. **Pregnancy and lactation:** No adequate data available. There are literature reports where transplacental passage has been demonstrated. Animal studies show no evidence of teratogenicity. Zarzio should be used in pregnancy only if the expected benefit outweighs the potential risk to the fetus. Use whilst breast-feeding is not recommended. **Side effects:** *Serious.* Pulmonary adverse reactions (haemoptysis, pulmonary haemorrhage, pulmonary infiltrates, dyspnoea and hypoxia), splenic rupture, hepatomegaly, severe allergic reaction (anaphylaxis, angioedema, urticaria, rash). *Common:* Mild to moderate musculoskeletal pain, blood alkaline phosphatase, blood lactate dehydrogenase (LDH) increased, gamma-glutamyltransferase (GGT), blood uric acid increased (reversible, dose-dependent, mild or moderate), leucocytosis, thrombocytopenia, splenomegaly (generally asymptomatic, also in patients), anaemia, headache, epistaxis, diarrhoea, cutaneous vasculitis (during long term use), alopecia, rash, osteoporosis, arthralgia, blood glucose decreased and injection site pain. *Uncommon:* Hypotension, spleen disorder, rheumatoid arthritis and arthritic symptoms exacerbation, aspartate aminotransferase (AST) and blood uric acid increased (transient, minor), haematuria and proteinuria. *Rare:* Vascular disorders including venoocclusive disease and fluid volume disturbances. *Very rare:* Pulmonary oedema, interstitial pneumonia, pulmonary infiltrates, Sweet's Syndrome, cutaneous vasculitis, Micturition disorders (predominantly dysuria), Haemoptysis, pulmonary haemorrhage, pulmonary infiltrates, dyspnoea and hypoxia. **Pack sizes/cost: (excl VAT):** Both strengths are available in packs of 5. 30 MU/0.5 ml: £295.00 and 48 MU/0.5 ml: £470.00. **Legal Category:** POM. **MA Holder:** Sandoz GmbH, Biochemiestr. 10, A-6250 Kundl, Austria. **Local representative:** Sandoz Ltd, Frimley Business Park, Camberley, Surrey, GU16 7SR. **MA No.** Zarzio 30 MU/0.5ml x 5 pre-filled syringes EU/1/08/495/003 Zarzio 48 MU/0.5ml x 5 pre-filled syringes EU/1/08/495/007. **Last revision of text:** July 2010. Refer to Summary of Product Characteristics for further information before prescribing. EU/1/08/495/1-8 001v4

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Sandoz Ltd, 01420 478301 or uk.drugsafety@sandoz.com.

Date of Preparation: July 2010. EU/1/08/495/1-8 010v2

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Diary of a weight management service: part 1

Weight management is a key service opportunity for community pharmacy if the sector is to embrace its clinical role and help patients lead healthier lives. Pharmacy-led schemes have already received backing from organisations such as the National Obesity Forum, but nationally the service is still in its infancy. To help inspire and plan your own programme, C+D is following two sets of pharmacists and patients to show you how a service really works in practice. Follow their progress at www.chemistanddruggist.co.uk

Weight expectations

All pharmacies have some patients who would benefit from losing weight. C+D is following two pharmacies offering rather different programmes to find out how you can best go about helping them. **Zoe Smeaton** reports

PROGRAMME 1

ASDA PHARMACY

The programme

The Asda Pharmacy weight management plan is based on patients adopting a healthy lifestyle – so exercising more and eating healthy meals that are low in fat. One tactic used by many patients is keeping a food diary and pharmacists can offer help with this and with looking at and learning from it throughout the process. Pharmacists also discuss motivational tactics with patients as they go along to help them stick to their programme.

Patients can expect to lose weight gradually and if they manage to keep up the lifestyle changes this should stay off. It will also improve their general health and wellbeing.

Meet the pharmacist

Ruksana Choudhury, Asda Pharmacy, Gateshead

The idea to run a weight management programme came about after I attended a course on general health and cardiovascular risk. The course suggested pharmacists could offer such programmes and we decided we'd like to give it a go.

Unfortunately we weren't able to secure any local funding for a programme, but with Asda's support we decided to go ahead and run a pilot to get experience in setting up and running the service. We contacted the PCT and were able to obtain leaflets on topics like healthy eating and exercise to give to patients. Next we started trying to find staff members with BMIs above 25 who could take part in our scheme. Denise Laidlaw was one of the patients who enrolled.

In the initial discussions with patients I take about 20 to 30 minutes, measuring their BMI and explaining the results to them. I also discuss their eating habits and physical activity levels and I explain how these could be improved.

I focus on why they are there and I try to learn whether they really want to lose weight – I need to find out if they are really motivated to lose some weight. I don't try to persuade people to do it if they don't want to, but most people are quite interested when you talk about how it might improve their health. I then talk to them about how they might lose weight.

This is Denise's second time around on my programme – she initially lost weight but now feels she would benefit from a booster to lose some before her holiday.

Meet the patient

Denise Laidlaw (pharmacy manager)

Following a training course, some of my pharmacists were quite keen to offer a weight management programme for patients. As pharmacy manager, I looked into funding and when it became clear there wasn't any available I decided to go ahead anyway so the pharmacists could get some experience. Hopefully if funding does become available later this will stand us in good stead to bid for any services.

All of this coincided with some news at home. My husband was diagnosed with type 2 diabetes and his doctor said if he didn't do something to alter his lifestyle then he might end up on insulin, which was a big shock for us. He wanted to make changes and I decided I would join him as I thought I could also do with losing some weight myself.

When I thought about it I realised that I'd been giving my patients advice about cardiovascular disease and healthy living for years but not doing any of it myself. I'd never really considered it before, but now I had this incentive I knew I wanted to change my lifestyle completely.

I think it was easier for me to adopt a healthy lifestyle because I already had the background knowledge about the role of physical activity and things like that. And this programme is very much designed around the patients themselves making lifestyle choices.

The first time around working with my pharmacist I lost just short of three stone. I do eat a healthy diet now anyway, but I'm going on holiday this year and would like to lose some more weight in time for that. I'm keen to start seeing the pharmacist again as I'd like some support to help me do that.

PROGRAMME 2

ROWLANDS PHARMACY

The programme

The Celebrity Slim programme is a partial meal replacement plan in which patients replace two meals a day with a shake, soup or bar and eat one carbohydrate-free, but balanced, meal. All carbohydrates included in the programme are contained in the meal replacement products. Participants are also allowed three snacks a day, which should be healthy, for example fruit or natural yoghurt.

Most people stay on the plan for eight to 12 weeks. Patients are encouraged to eat healthily afterwards – the "maintenance phase" – and educated on how to do this, such as by considering factors such as the glycaemic index of food.

Meet the pharmacist

Edward Scarisbrick, Rowlands Pharmacy, Newton Le Willows

When Rowlands launched the Celebrity Slim programme it provided full training for

me and my staff, presenting the evidence backing the diet and covering topics such as patient FAQs and how we should answer them.

I wondered if this was just a fad diet and whether people would put weight back on a few months later or if there were associated health risks. So I decided to try it myself. I lost eight pounds in my first week and I really didn't find it was any effort to follow the plan. I was eating regularly so I didn't feel hungry, and I became aware of just how much carbohydrate I used to eat.

Following the diet myself has really helped me with the service. For one thing I actually had customers coming in saying: "Gosh, have you lost weight?" and commenting on how well I looked. I was then able to tell them how I'd done it and show them the product and some of them were interested in trying the diet themselves.

But I'm also able to talk about my experience if they have any questions or difficulties and it can help motivate them to see that I've been through it and have succeeded.

During the first consultation I measure the patient's BMI and then show them on a chart where they are relative to the ideal weight. Patients quite like that because it's a visual aid – they can see where they are now, and then where their target is.

Starting the diet has to be their decision, and you don't want to nag them, but you also need to make it clear that the door is open for them to come in with questions anytime.

Meet the patient

Mary Ditchfield

I want and need to lose two stone in weight. I've put weight on over the last few years, possibly because I have an underactive thyroid.

Losing so much weight seems like a mammoth task to me, especially as other diets have not been successful – it is a known fact that my thyroid makes weight difficult to lose and that I'll lose weight at about half the rate of people with a fully functioning thyroid.

I heard about the Celebrity Slim diet but I felt nervous about going into the shop. I wondered if I really wanted to do it as I thought I'd be hungry all the time. But I spoke to the pharmacist and he talked me through the process and told me about his own experiences losing weight on the diet.

I like that I could lose weight quite quickly, and that I don't have to be weighed in front of other dieters who tut if I don't lose weight.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on weight management

REFLECT	Could your patients benefit from a weight management programme?
PLAN	Think about how you could set up the service.
ACT	Talk to the pharmacy manager or owner about your plan and involve staff in launching a scheme.
EVALUATE	Has the scheme improved your skills as a pharmacist and helped your patients?

I find the shakes tasty and filling, which is a surprise. And as I love fruit it's easy to have this as a snack, although on one or two days of my first week I didn't feel hungry and only realised I had not had a snack when it was time for my next shake. I also feel I have much more energy.

No alcohol this week and my exercise was Pilates twice and lots of gardening.

Find out how Ms Ditchfield and Ms Laidlaw are getting along on C+D's weekly weight management blogs

www.chemistanddruggist.co.uk

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CAREERS

Your rights when you're ill

What you need to know about absence from work due to sickness – **Alan Massenhove** explains

Sickness in the workplace can cause stress for employer and employee alike. Fundamentally, to benefit from the statutory protection and entitlements the law affords if you are absent due to sickness or injury, as well as any related contractual benefits, you must understand and follow your obligations.

Read the small print

Firstly, you should always comply with any sickness absence provisions in your contract of employment, and follow any sickness absence policy published by your employer. Where the absence has been caused by bullying, harassment or victimisation, you should also follow any relevant policies your employer may have.

Prove your case

If you are absent because of sickness you must be able to demonstrate that you are genuinely unfit for work. Any absence that is not genuine is likely to amount to misconduct, and could result in disciplinary action.

Since April 6 it is now possible to request from your GP and provide to your employer a 'statement of fitness for work', or 'fit note'. A fit note amounts to evidence of incapacity for statutory sick pay (SSP) purposes, and in most cases should also suffice for contractual sick pay purposes.

Contracts of employment often provide employers with a right to require the employee to attend a medical examination. When requesting a medical report your employer must comply with the Access to Medical Reports Act 1988, which requires them to inform you of your legal rights in a prescribed form.

Claim your sick pay

Employers are generally under no statutory obligation to pay employees who are absent from work on account of sickness. Instead, employers need only pay SSP. But if your terms and conditions of employment include provision for contractual sick pay, then the employer must act in accordance.

The SSP scheme is complicated, and HM Revenue & Customs offers guidance at www.hmrc.gov.uk/calcs/ssp.htm. In summary, eligible employees receive no payment for the first three days of sickness absence, and thereafter they will receive SSP for up to 28 weeks. After 28 weeks, employees must rely upon any other state benefits they may be entitled to.

A condition of entitlement to SSP is that you must notify your employer of any date on which you are unfit for work within seven calendar days of that date. A failure to comply with this condition can result in SSP being withheld.

Another condition is that you must produce evidence of incapacity. During the first seven days of absence your employer may only ask for "reasonable evidence" – typically self-certification. Fit notes may not be demanded until after this period. A failure to comply with this condition does not entitle your employer to withhold SSP.

It would be a wise move to check your contract of employment and any sickness policy to establish whether you have any entitlement to contractual sick pay over and above SSP. Even if you have no express entitlement, if your employer has habitually paid discretionary sick pay in the past then there may be a case to argue that a contractual entitlement has arisen.

You must demonstrate you are genuinely unfit for work if you take time off sick

Dismissal danger

If you are absent on account of sickness you can be fairly dismissed for one or more of three reasons. Most dismissals will be by reason of your "incapability" to do the job. Where the absences are short term, intermittent and persistent, and the absences have a significant detrimental impact on your employer's business, then your dismissal may be by reason of "some other substantial reason".

Unauthorised absences or failures to comply with sickness procedures may justify dismissal by reason of "misconduct". However, every dismissal must be fair and employers must act reasonably in treating the absence as a sufficient reason for dismissal. If facing termination, you should take legal advice.

Alan Massenhove is a solicitor at Sykes Anderson

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on sickness absence

REFLECT	Do I understand my rights and responsibilities if I or my staff are off work sick?
PLAN	Read this article and consider which aspects of the law and my/my staff's employment contracts I need to revisit.
ACT	Revisit relevant sections of employment contracts.
EVALUATE	Do I know what to do if I or my staff are absent from work due to illness?

Other factors influencing sickness rights

HOLIDAY

Following recent case law and directions from the European Union, statutory holiday continues to accrue during any period of sickness absence, even rolling over from one holiday year into the next.

The rulings mean statutory holiday cannot be taken during sickness absence. If you are in this situation you must take the holiday after you have returned to work. If you do not return, and the employment is terminated, your employer must pay you in lieu of the holiday accrued but untaken due to the sickness.

PREGNANCY-RELATED ILLNESS

As a general rule, any absence resulting from a pregnancy-related illness can be treated the same way as any other sickness absence. This includes absences after the birth, for example for post-natal depression. Once maternity leave starts, special statutory maternity leave and pay rules will apply.

PENSIONS AND EARLY ILL-HEALTH RETIREMENT

If you are on long-term sick leave and a member of a pension scheme that provides for early ill-health retirement, your employer must consider this option before any decision to dismiss is made. A failure to do so could result in your being able to claim unfair dismissal.

DISABILITY DISCRIMINATION

Individuals who are absent from work because of illness may be protected under the Disability Discrimination Act 1995 (soon to be the Equality Act 2010). If you are an employee with less than one year of continuous service you may bring a discrimination claim if you do not qualify to bring an unfair dismissal claim.

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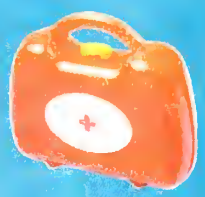

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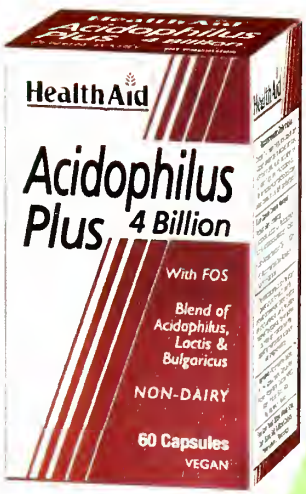

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Postscript...

Charity summer bonanza – part one

At the start of the year Postscript asked for your charity events – and the results have been staggering. So staggering, in fact, that we're not sure if we can squeeze everyone in. But we're going to have a go anyway.

Last month Masons Chemist's four pharmacies teamed up to raise more than £1,500 for Cancer Research, when the staff joined in the 5km Race for Life around Loughborough University's campus.

And the Advance Pharmacies Group also helped drum up money for a worthy cause, when a team took on a dreaded 26-mile, three-peak challenge to raise £2,000 for Heart Research UK.

Elsewhere, Midcounties Pharmacy made a difference to St Whites Primary School in Cinderford, when they donated a playground hamper packed full of skipping ropes and footballs to the school. St Whites is just one of 10 schools to benefit from donations from The Midcounties Co-operative during its Co-operative Fortnight charity drive.

And speaking of skipping, all 32 branches of Whitworth Chemists will be hopping mad on July 12 as they take part in a skipathon relay on behalf of the British Heart Foundation. The pharmacies have already drummed up £6,000 for the heart disease charity this year.

Midcounties Pharmacy's Nick Porter and Genna Bishop deliver footballs to St Whites Primary School in Cinderford

Phew. And it's not over yet – there'll be another charity round-up in the next couple of weeks.

C+D reader of the week

Meet Stephen Foster of Pierremont Pharmacy in Kent and find out what a man brave enough to jump out of planes wanted to do for a living when he was little.

If you could choose any career other than pharmacy, what would you pick? I wanted to be a professional cricketer when I was younger but I didn't quite make the grade. That would be my dream job.

If you could change one thing about pharmacy what would it be? I'd change the way we're regarded by other healthcare professionals. I'm doing quite a lot of work on that at the moment, working with clinical leaders.

Which service would you most like to see all pharmacies providing? I'm a specialist in respiratory conditions and allergies and I'd like to see pharmacies involved in early interventions for COPD. We do a lot of work on smoking cessation and we could link screening to that.

What do you like for breakfast before a day in the dispensary? It's not particularly healthy, but there's a nice café near the pharmacy so I sometimes get bacon sandwiches for the team. Mine's with brown sauce every time.

What is the scariest thing you have ever done? A parachute jump, especially as I had never been on a plane before. It was a charity jump raising money for the Motor Neurone Association and it was a fantastic experience.

What was the last DVD you watched? Angels and Demons with Tom Hanks. I've read all the Dan Brown books and I bought it as soon as it came out.

What should we ask the next interviewee? I'd like to know how they are getting involved in the development of the profession.

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

The Victorian Pharmacist

"No dispenser should come to work in his dressing-gown and slippers"

Sir,

I have recently been perusing the latest edition of Dr Hermann Hager's "Technik der Pharmaceutischen Receptur". Now, having obtained permission from Dr Hager, I thought I should share his views. While I have naturally eliminated such matters as have no interest to English readers, these notes still have a certain German flavour, and will present ideas which have long since lost all novelty to readers. However, I hope at least some of the hints prove useful.

Dr Hager writes: "The dispenser must cultivate habits of order and cleanliness. Dirtiness and untidiness in dress in the dispenser must give the public an unpleasant impression. Such practices as pressing corks with the teeth, holding powder-envelopes in the mouth, shaking up mixtures with the finger over the mouth of the bottle, breathing on pills to be silvered etc should be avoided. Decent and becoming manners are essential. No dispenser should come to work in his dressing-gown and slippers. Scolding the apprentice or joking with fellow-assistants are equally out of place; and, besides, a strict sense of duty towards the prescriber and patients must be entertained by everyone who would be a true pharmacist. In the adoption of expensive or cheap adjuncts to the preparation of prescriptions, such as covered jars, stoppered bottles and the like, regard should always be given to the circumstances of the customer."

There is no doubt Dr Hager's concepts are most sensible notions that should be adopted by all pharmacists.

The Victorian Pharmacist's comments come from a series taken from Dr Hager's recommendations, published by C+D in 1884, when it was OK to give the best stuff only to rich customers. Have you ever turned up to work in a dressing gown and slippers? Let the Victorian Pharmacist know by emailing him at: postscript@chemistanddruggist.co.uk

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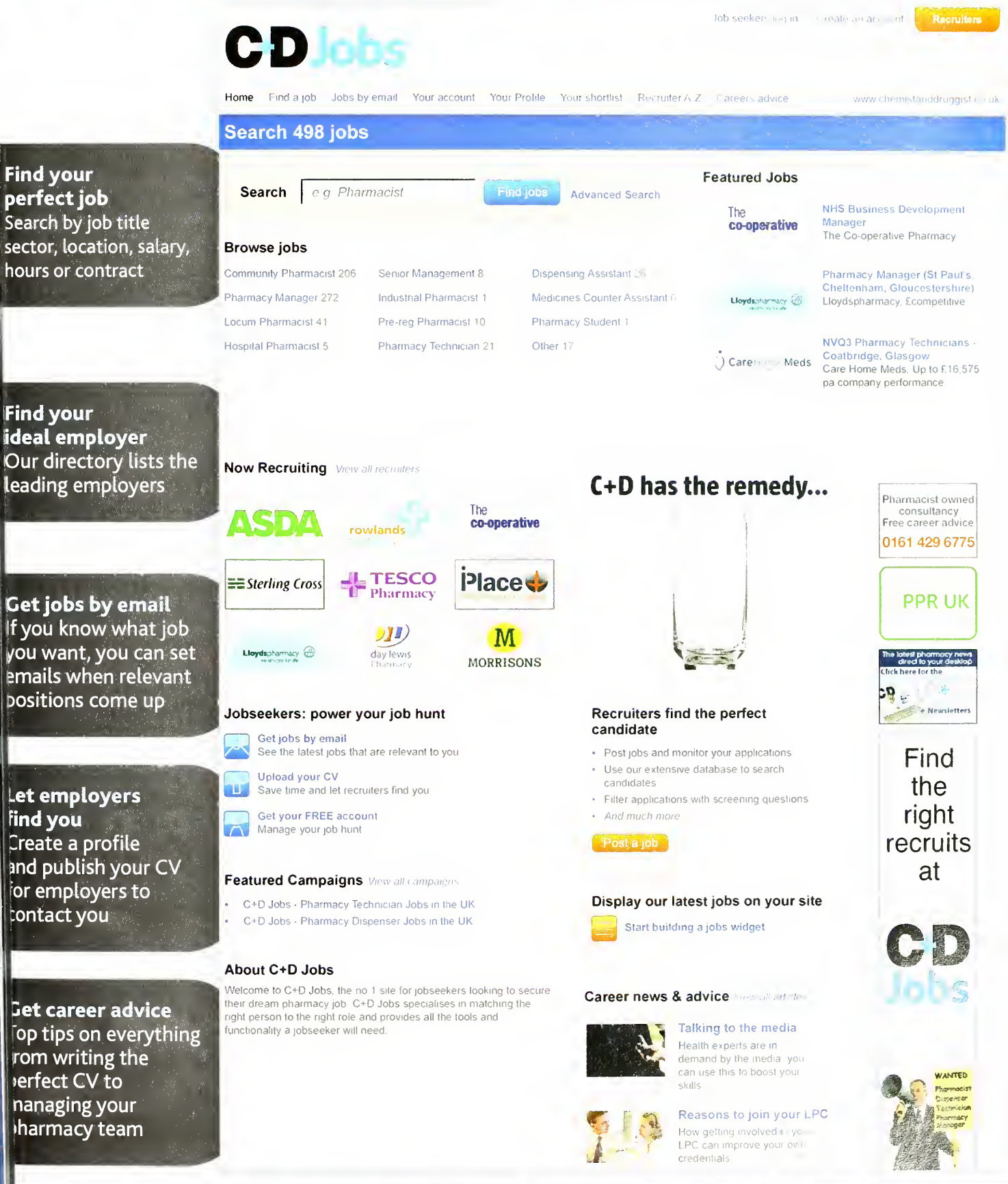

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